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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing held
in Ottawa, Ontario, on the 27th
day of March, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

Miss ALICE GIRARD, R.N.

Dr. C.L. STRACHAN

Dr. ARTHUR F. VAN WART

Mr. M. WALLACE McCUTCHEON, Q.C.

Prof. O.J. FIRESTONE

Dr. DAVID M. BALTZAN

COMMISSION COUNSEL:

Mr. R.N. HALL, Q.C.

COMMISSION SECRETARY:

Mr. N. LAFRANCE



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THE CHILDREN'S AID SOCIETY OF
OTTAWA

7806



Ottawa, Ontario,
Tuesday, 27th
March, 1962.

--- On commencing at 10 a.m.

MR. HALL: Mr. Chairman and members of
the Commission, the first submission this morning is
that of the Royal Canadian Legion and I would ask that
their brief be filed as Exhibit 207.

--- EXHIBIT NO. 207: Submission of the Royal Canadian
Legion.

SUBMISSION OF THE ROYAL CANADIAN LEGION

Appearances: Mr. D.M. Thompson
Mr. Murray MacFarlane

MR. THOMPSON: Mr. Chairman, Commissioners
of the Royal Commission on Health Services, the privilege
accorded the Royal Canadian Legion to appear before this
Royal Commission on Health Services and to present this
Brief on behalf of our membership is one which is not
lightly appreciated. Throughout the years of our history
as an organization speaking officially for the thousands
of Canadians who have served their country during periods
of war or unrest, the Legion has recognized the value that
may accrue from official and public enquiries and thought-
ful presentations made thereto. The conclusions that
have been reached, therefore, are the result of careful
analysis and study of the problems related to that aspect
of the Legion's operation which is relevant to this
enquiry.

2. The Royal Canadian Legion is an
organization of Canadian ex-servicemen which acts, in



1 particular, on behalf of its membership of a quarter of
2 a million persons, and, in general, on behalf of all of
3 those and the dependents of those, who have at any time
4 served in the armed forces. It is therefore representa-
5 tive of the largest heterogeneous group of the Canadian
6 population having a common denominator. The objectives
7 of the Legion are, of course, set out in detail in the
8 General By-Laws of the organization, but broadly and
9 briefly as they apply to this study they are to promote
10 the welfare, maintenance and comfort of those who served
11 and their dependents. Since World War I the legislative
12 processes which have evolved to benefit Canada's ex-
13 servicemen and their dependents have been the constant
14 concern of the Legion, and its efforts to mold and modify
15 the legislation to the greater benefit of this segment
16 of the population are manifest in the present high stan-
17 dards that exist.

18 3. As stated, our concern is for that
19 group which is identified by prior service in the armed
20 forces. For this reason, therefore, and because it is
21 national in scope, the Legion's activity is based primarily
22 on the federal level. It is highly cognizant of the fact
23 that the rights of those it serves include that of citi-
24 zenship in general and therefore Provincial and Municipal
25 legislation is of concern, but the knowledge that the
26 greatest benefit is derived through endeavouring to
27 influence the Federal authority demands concentration in
28 this area.

29 4. It is the conclusion of the Legion
30 that while at present there exists in Canada an adequate



1 system for the treatment and care of Canadian ex-service-
2 men, and while it is recognized that under the circum-
3 stances that presently exist this is a diminishing
4 group, the present standards must be maintained and
5 where indicated expanded and under no circumstances
6 should the facilities provided for the treatment of
7 veterans be converted to the treatment of others to
8 exclude the prior right of the veteran.

9 5. Departmental medical care for
10 veterans in Canada is maintained by the Treatment
11 Services Branch of the Department of Veterans' Affairs.
12 In each of the provinces except Prince Edward Island
13 there are modern treatment facilities operated by the
14 Department and in addition supplementary district facili-
15 ties in designated wings of public hospitals. As well,
16 in an emergency situation, a departmental patient may be
17 cared for in a local hospital by express authorization.

18 6. The Department has accepted as a
19 responsibility the treatment of pensioners for their
20 pensionable disabilities and War Veterans' Allowance
21 recipients for any condition. These are two completely
22 dissimilar groups. Pensioners are those ex-servicemen
23 to whom the Pension Commission has granted entitlement
24 in respect of a disability arising through their service
25 in the Armed Forces. They are always entitled to free
26 treatment by the Department of Veterans' Affairs for
27 these conditions. Veterans who are in receipt of War
28 Veterans' Allowance, including those who could qualify
29 for an allowance were they not in receipt of Old Age
30 Security, are entitled to free treatment for any disability.



1 Qualification for an award under this legislation is
2 based on service, income and personal and real assets.
3 Beyond this, those who have had overseas service are
4 privileged to the use of Departmental facilities where
5 they exist on the basis of part or non-payment depending
6 on the financial ability of the veteran to pay. While
7 the patient requiring treatment for his pensionable
8 condition or the W.V.A. recipient cannot be excluded, a
9 veteran seeking treatment for a non-pensionable condition
10 on a part-payment or non-payment basis will only be
11 accommodated where the physical space is available.

12 7. It is in this area that there has
13 been some concern in the past and may be of concern in
14 the future. There have been instances where the Govern-
15 ment, when accommodation was available, has made use of
16 Departmental institutions for the treatment of various
17 non-veteran patients such as fishermen, mariners and
18 immigrants. Certainly the Legion does not wish to suggest
19 that hospital space should not be utilized to the fullest,
20 but we would not wish to see the services over-taxed to
21 such an extent as might tend to limit the treatment of
22 veterans who wish to be admitted under the provisions of
23 the legislation by the payment of certain fees.

24 8. The Chairman has remarked at the
25 Preliminary Meeting held on September 27th, that while
26 the field of health and health services is largely under
27 Provincial jurisdiction, the Federal Government has, in
28 recent years, provided substantial assistance and in
29 special circumstances concerned itself with providing
30 health services.



1 9. One of these special circumstances
2 involves the care of veterans and has resulted in the
3 establishment of treatment facilities at a uniform level
4 throughout the country. This, then, has resulted in the
5 veterans in the Atlantic provinces being assured of the
6 same calibre of treatment as those in Central or Western
7 Canada and also that they will receive the same regime
8 of treatment when the move from one province to another
9 as necessity demands. This enables the free use of
10 consultants in "foreign" districts and allows the
11 centralization of specialized treatment services.

12 10. Through the office of the Director
13 General of Treatment Services treatment facilities and
14 programs are under constant supervision and review.
15 The services of outstanding consultants, surgeons, inter-
16 nists, etc., applied in one area may then be placed at
17 the disposal of all the veterans' hospitals through
18 transfer of technical knowledge and techniques. This
19 central supervision enables the establishment and mainte-
20 nance of the highest possible standard of treatment. It
21 avoids the conflict of individual hospitals and their
22 staffs which prevents the exploitation of new skills.

23 11. If the care of veterans was placed
24 under the jurisdiction of the ten provincial governments,
25 the Legion foresee that there can be no escape from a
26 loss of this uniformity of treatment and the advantages
27 that accrue from it.

28 12. It is, of course, to be anticipated
29 that with the advance of years more veterans eligible
30 for treatment as of right will have to be accommodated.



1 This, despite the natural decrease in their numbers, is
2 due largely to the influence of advancing years making
3 the individual more susceptible to illness, but also
4 brought about by increasing numbers gaining such eligi-
5 bility by becoming W.V.A. recipients. This will mean
6 that the existing facilities will have to be preserved
7 intact, or, in fact, increased. In any event there is
8 no indication whatsoever that curtailment of services
9 can be justified. We feel, too, that some consideration
10 is owed to those who may seek Departmental treatment only
11 as a privilege. As the anticipated over-taxing of
12 general hospitals occurs these veterans could benefit
13 more from the availability of space in Departmental
14 institutions and we believe that accommodation should
15 always be guaranteed the veteran, regardless of the
16 type of care sought, before making use of these institu-
17 tions to provide for non-veteran groups.

18 13. We thank you for the opportunity
19 of presenting this Brief and would assure you that our
20 officials are most anxious to assist you in your delibera-
21 tions in any way possible.

22 THE CHAIRMAN: Thank you, Mr. Thompson.
23 If I might just paraphrase it very incompletely, you
24 are reasonably satisfied with the status quo?

25 MR. THOMPSON: Right, sir.

26 THE CHAIRMAN: Then, you make the state-
27 ment at the top of page 4 that if the care of veterans
28 passed to the jurisdiction of the Provincial Governments
29 you foresee from this loss of this uniformity of treatment
30 and other advantages.



1 Is it your view that if there should be
2 a national program of health services of some kind that
3 the care of veterans should be excluded from that
4 service, that it should by-pass them completely?

5 MR. THOMPSON: Well, sir, our view on
6 that would be that what we now have for veterans is of
7 a high quality across the country.

8 It is our concern that this not be in
9 any way changed in arrangement. I think whilst this
10 has not been established, Legion policy, in answer to
11 the specific question you asked, I would think that for
12 the time being we would certainly want to see the
13 veterans' treatment facilities retained intact.

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1 THE CHAIRMAN: You want to see the plan
2 before passing an opinion on it?

3 MR. THOMPSON: I believe this is fair sir
4 because what we have now works to the advantage of the
5 veterans and the exchange of patients from one
6 district -- for instance, if a man in Nova Scotia needs
7 a particular kind of examination or treatment that is
8 available in Montreal or Toronto, this can be obtained
9 through the Department of Veterans Affairs by sending
10 the man to Sunnybrook or to Montreal, or wherever the
11 need may be.

12 COMMISSIONER McCUTCHEON: The fact is when
13 the Hospital Insurance scheme came in it merely added
14 something. The veterans got all the benefits of that
15 plus what they already had?

16 MR. THOMPSON: Right sir.

17 COMMISSIONER McCUTCHEON: That is the position
18 you want to keep it in?

19 MR. THOMPSON: Right.

20 COMMISSIONER VAN WART: Would you want your
21 families covered under the plan that is in?

22 MR. THOMPSON: This certainly sir would be
23 something that would be an added advantage, and certainly
24 would be of great help to many of these people who are
25 on -- take a war veteran allowance recipient who has
26 limited income, it would be a good boon to their
27 welfare if their families were provided for under an
28 overall plan.

29 THE CHAIRMAN: As you will understand, in
30 any program it would be, of necessity, provincial based.



1 It may well have variations between any methods between
2 the provinces and one of the variations that one can
3 anticipate may be the very thing that has happened in
4 connection with hospitalization. That is, one
5 province there may be a premium. Another province
6 a tax is not collected by premium but by a sales
7 tax or even some other way of collecting the tax might
8 be devised.

9 Have you any viewpoint to express on the
10 situation in a province where a premium, compulsory
11 premium, that is from all citizens of the province is
12 collected in terms of the veteran who is already
13 covered and who gets nothing for his premium?

14 MR. THOMPSON: You are referring, I take it,
15 sir, not to the veteran, for instance, who is a
16 War Veterans Allowance recipient as coverage here
17 because this situation now exists to some degree with
18 the War Veteran Allowance recipient who is covered
19 for treatment and in the province where there is now
20 a premium, the Department of Veterans Affairs makes
21 payment to the recipient for the premium portion
22 covering his treatment.

23 THE CHAIRMAN: I see. All right. Is that
24 the answer then? There is no -- or his premium is
25 refunded?

26 MR. THOMPSON: That is right sir. Now this
27 I suppose if you were to carry it eventually to the
28 overall picture, that now the man who has disability,
29 say he has a gunshot wound and he needs treatment
30 from time to time, he would still be paying his



1 premium under the present setup; under the province
2 that is paying the premium he doesn't get it refunded
3 but his premium goes towards his treatment for his
4 other condition for which he does not hold entitlement.

5 THE CHAIRMAN: The War Veterans Allowance
6 person, once he has qualified for that, comes on the
7 list of those who receive it, he gets treatments for
8 all ailments. What about that premium?

9 MR. THOMPSON: That is refunded to him now
10 sir.

11 THE CHAIRMAN: That is the one that is
12 refunded?

13 MR. THOMPSON: Yes.

14 COMMISSIONER McCUTCHEON: In effect he has
15 been subjected to a means test?

16 MR. THOMPSON: Yes.

17 THE CHAIRMAN: What is the basic qualification?

18 MR. THOMPSON: From a means test point of view
19 sir?

20 THE CHAIRMAN: Yes.

21 MR. THOMPSON: On the War Veterans Allowance
22 the man is allowed to have real property to the value
23 of \$9,000.00. He is allowed to have ---

24 THE CHAIRMAN: That would be his home or
25 something?

26 MR. THOMPSON: Yes, his home. He is allowed,
27 if single, to have \$1250.00 personal -- it can be
28 cash in the bank, bonds, or if he is married \$2,500.00
29 and his income from all sources, if single, including
30 the allowance he gets and other income cannot exceed



1 \$1,296.00 a year and if married \$2,088.00.

2 COMMISSIONER McCUTCHEON: That includes the
3 allowance?

4 MR. THOMPSON: Yes.

5 COMMISSIONER McCUTCHEON: In other words,
6 the allowance brings whatever income he has up to that
7 maximum and no more?

8 MR. THOMPSON: That is right. There is some
9 provision for casual earnings over and above this
10 that are considered as exempt income. This depends
11 much on the man's state of health, as to what degree
12 he can avail himself of these things.

13 THE CHAIRMAN: To what extent is casual? I
14 mean when does it become not casual in volume?

15 MR. THOMPSON: He can work up to four
16 months steady employment, up to four months in the year.
17 Once it becomes over four months, once his employment
18 extends beyond four months then none of this is
19 considered as casual and if his employment is less than
20 four months, he can take it as excluded and count it
21 as exempt.

22 THE CHAIRMAN: Basicially he might earn up
23 to \$800.00, \$1,000.00 in four months?

24 MR. THOMPSON: Up to \$600.00 and \$900.00
25 married. Sir for the man over seventy who is getting
26 old age assistance, there is this additional \$10.00,
27 this recent increase in old age pensions was also put
28 under the category of exempt income.

29 THE CHAIRMAN: Dr. Baltzan have you any
30 questions?



1 COMMISSIONER BALTZAN: Yes, gentlemen, just
2 help me in getting things straight. The differentiation
3 here, just to understand: "Pensioners are those
4 ex-service men who whom the Pension Commission has
5 granted entitlement in respect of a disability arising
6 through their service in the Armed Forces." In other
7 words, these people for their disability have all the
8 necessary medical care without question?

9 MR. THOMPSON: That is right.

10 COMMISSIONER BALTZAN: For the pensioner?

11 MR. THOMPSON: That is right.

12 COMMISSIONER BALTZAN: What about the non-pen-
13 sioner and he is wounded, an ex-serviceman?

14 MR. THOMPSON: If a man -- if I understand
15 your question correctly, you are speaking about the
16 man who is on disability for which he doesn't hold
17 pension entitlement?

18 COMMISSIONER BALTZAN: Well let's put it this
19 way: he has a war wound, anything arising out of that
20 he is covered. Supposing he has an automobile accident
21 and then something else happens. What happens there?

22 MR. THOMPSON: He has an automobile accident
23 after discharge?

24 COMMISSIONER BALTZAN: Provided he has no
25 insurance.

26 MR. THOMPSON: Is the automobile accident after
27 discharge?

28 COMMISSIONER BALTZAN: Yes.

29 MR. THOMPSON: If the automobile accident, I
30 presume in this case has no connection whatever with



1 his pension disability, then he would come -- he could
2 come under a separate clause of veterans depending on
3 his service but with his disability pension that he
4 has, this would automatically make him eligible for
5 treatment on a sliding scale basis depending on his
6 assets, the length of time that it was expected he
7 would be undergoing treatment and on what they call
8 an adjusted income. If they feel he will need so
9 many months hospitalization, so many months convalescence,
10 they will figure this all out, and if it is below a
11 certain level he can have free treatment for this
12 hospitalization for this automobile accident although he
13 might pay half of the cost.

14 COMMISSIONER BALTZAN: Is that spread over
15 to his family at all?

16 MR. THOMPSON: No sir, this applies only to
17 him.

18 COMMISSIONER BALTZAN: Then the next thing,
19 veterans who are entitled to War Veterans Allowance,
20 what class are they?

21 MR. THOMPSON: The basis of eligibility of
22 that?

23 COMMISSIONER BALTZAN: Yes.

24 MR. THOMPSON: There are two main points. One
25 is service eligibility and the other is a means test.
26 Now the service eligibility, if a man served in a
27 theatre of war in World War I and World War II, or if
28 he is on disability pension, whether he served in
29 Canada or overseas, if he served in both wars, both
30 World War I and World War II, even if his service was



1 confined to Canada he can be eligible from a service
2 point of view for War Veterans Allowance.

3 COMMISSIONER BALTZAN: Not necessarily
4 meaning that he has suffered a wound traceable to war?

5 MR. THOMPSON: No, that is right. When the
6 legislation first came in it was commonly referred to
7 as the burnt out pension and I may explain the
8 philosophy behind it. It was brought in on the
9 acceptance of the assumption sir that men who had front
10 line service, living under active service conditions
11 did lose, in many cases, something from their vigour and
12 their drive and their ability to fit back in and become
13 rehabilitated and make up for those war years. This
14 was the original basis of War Veterans Allowance.

15 COMMISSIONER BALTZAN: Just one more thing sir.
16 Speaking at the bottom of the page "a veteran seeking
17 treatment for a non-pensionable condition on a part
18 payment or non-payment basis..." how is that applied?

19 MR. THOMPSON: Well that sir would be the
20 type of person that we referred to in connection with
21 the automobile accident and they have a sliding scale.
22 If they find he is going to be in the hospital three
23 months, and then needs three months convalescence
24 there is six months of his earnings. They will
25 look at what the cost of hospitalization would be for
26 that period. How much this would reduce his assests
27 and if his adjusted income is not above \$3,000.00
28 for that year, he pays on a sliding scale. The
29 Department has an overall sliding scale which includes
30 all services, doctors, nurses, drugs, and so on, every



1 departmental charge and if his adjusted income is
2 \$1,296.00 or less, there is no charge. I mentioned
3 \$3,000.00 earlier. If he is above that he cannot come
4 under this at all. If it is \$1,296.00 or less then
5 he doesn't have any payment to make or he can pay a
6 charge of one per cent of the adjusted income. Where
7 such adjusted income exceeds \$1,296.00, but does not
8 exceed \$1300.00 such percentage of the entire adjusted
9 income being increased by one per cent for each
10 additional \$100.00 of the adjusted income or part
11 thereof, well, as I said the easiest way to describe
12 it is a sliding scale which works \$1,296.00 or under
13 they pay nothing and then as they go up above \$1,296.00
14 the percentage of the total cost they pay is increased.

15 COMMISSIONER BALTZAN: You don't find very
16 much difficulty in obtaining this information from
17 the applicant?

18 MR. THOMPSON: No. I would say not. They
19 make application to the Department. They have to fill
20 out a very detailed form of their income. We have
21 found some cases where there has been a slight
22 disagreement with the Department authorities on the
23 interpretation of the information provided but I
24 would say sir that by and large there has been a
25 very sincere attempt on the part of the Department
26 officials to make eligible those who come within these
27 provisions.

28 COMMISSIONER BALTZAN: On the part of the
29 applicant?

30 MR. THOMPSON: Oh very sincere on the part



1 of the applicant in many cases.

2 THE CHAIRMAN: Really what Dr. Baltzan is
3 asking: does the applicant resent having to expose
4 his financial position in order to qualify?

5 MR. THOMPSON: Well I think sir in fairness
6 that this is something that is dependent very much on
7 the individual's attitude but I would say by and large
8 there has not been this resentment. There certainly
9 are some individual cases but I think by and large that
10 it is accepted that there has to be some basis under
11 the legislation and if one wants this, then one must
12 provide the answers that are requested.

13 COMMISSIONER BALTZAN: Thank you for the
14 explanation.

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1 THE CHAIRMAN: Mr. Thompson, we have
2 been talking of those with war service injuries, and
3 so forth, either World War I or World War II. Now, we
4 have current army, navy and so forth, etc. What is
5 the position of those who are presently in the armed
6 services and who never saw active service in any theatre
7 of war?

8 MR. THOMPSON: Well, the same provi-
9 sions we have outlined here do not apply unless these
10 people are disability pensioners.

11 THE CHAIRMAN: They are in the service,
12 of course; there is an in-service taken care of for
13 medical and so forth while they are in the service, they
14 take sick and they go to the army hospital?

15 MR. THOMPSON: Yes.

16 THE CHAIRMAN: And if they have received
17 any injuries while in service, naturally I suppose that
18 is carried over discharge?

19 MR. THOMPSON: Yes, if entitlement can
20 be established and it was shown that service was the
21 main cause.

22 THE CHAIRMAN: Take a very plain case.
23 A man may fracture his arm while in the service, some-
24 thing that is proved by just looking at it, there is a
25 record. That is taken care of after discharge.

26 MR. THOMPSON: That is right.

27 THE CHAIRMAN: So that those people are
28 also in a measure within the provisions you are talking
29 about here this morning? I mean of being covered by
30 D.V.A. in some form or another.



1 MR. THOMPSON: In some form or another,
2 that is right, sir.

3 THE CHAIRMAN: What about their depen-
4 dents? While in service is there dependents' coverage,
5 too?

6 MR. THOMPSON: I would not want, sir,
7 to attempt to give you an answer on that that I would
8 guarantee to be 100% correct.

9 THE CHAIRMAN: We would have to get it
10 from the Department?

11 MR. THOMPSON: I think so, sir. I
12 would not want to be wrong in that.

13 THE CHAIRMAN: The next question automa-
14 tically is: they pay premiums for their families while
15 they are in service?

16 MR. THOMPSON: I think you find circum-
17 stances, where the families are in isolated outpost areas
18 to the families who live in the rest of Canada.

19 THE CHAIRMAN: Well, we will have to
20 get it from the Department what the family is expected
21 to do with the family allowance that is paid.

22 COMMISSIONER VAN WART: What has
23 happened recently in Ottawa is what you, no doubt, are
24 afraid of. I understand the veterans have been placed
25 now in tri-service hospital and receive their medical
26 care from tri-service personnel and not from the personnel
27 set aside for veteran treatment.

28 That is the sort of thing you are fearing,
29 is it?

30 MR. THOMPSON: No, we were more, sir,



1 referring to the situation that could exist. There you
2 still have a Federal Government agency and there should
3 be ample opportunity for complete integration of D.V.A.
4 and T.S.B.. with treatment services.

5 We were referring more if the D.V.A.
6 Hospital at Sunnybrook, Toronto, were to cease to be a
7 D.V.A. Hospital and all patients were to be fitted into
8 the general framework of patients because everyone was
9 a member of a common plan.

10 That is where we feel the veteran
11 could lose out in the service available.

12 COMMISSIONER VAN WART: Would you have
13 any objection to utilizing the extra space available in
14 Sunnybrook for active army personnel?

15 MR. THOMPSON: In Sunnybrook - this is
16 a D.V.A. Hospital - do we object to the Defence Depart-
17 ment putting national defence people in there?

18 COMMISSIONER VAN WART: Yes.

19 MR. THOMPSON: No, we don't, but we do
20 feel that a veteran who could be refused admission to
21 Sunnybrook, even though there is this part-payment plan
22 under D.V.A., he shouldn't be refused admission on the
23 grounds that the hospital is full of other than D.V.A.
24 patients.

25 COMMISSIONER VAN WART: In other words,
26 you wish priority over other admissions?

27 MR. THOMPSON: Yes, because the beds
28 are not there.

29 COMMISSIONER VAN WART: Would you have
30 any objection, if the plan came in, if the families of



1 the veterans could use some of that space?

2 MR. THOMPSON: I would think our organiza-
3 tion would not have any objection. We have discussed
4 this in years gone by. There is not a recent policy
5 decision on it.

6 COMMISSIONER VAN WART: The families,
7 of course, are not nearly so mobile as the veteran.

8 MR. THOMPSON: No, and I think this
9 could create a difficulty because of the hospital being
10 set up as a - I think in principle we wouldn't object,
11 but again we feel that the priority of admission would
12 have to be to the man who served and this would be the
13 priority consideration.

14 But we have no objection to the utmost
15 utilization being made of existing facilities for anyone
16 who is sick and in need of treatment.

17 COMMISSIONER VAN WART: As long as you
18 retain your priority and also the same standard of
19 medical attention that you are getting at the present
20 time?

21 MR. THOMPSON: Right, sir.

22 THE CHAIRMAN: Thank you very much, Mr.
23 Thompson, Mr. MacFarlane. Your brief is naturally
24 confined to a narrow area in the sense of discussion,
25 although we appreciate it and the importance of it in
26 the national picture.

27 We are grateful to you coming here
28 this morning and giving us your views.

29 MR. THOMPSON: Thank you very much, sir.



1 MR. HALL: Mr. Chairman, appearing for
2 the Welfare Council of Ottawa are Dr. J. Laycock, the
3 Executive Secretary, Miss Enid Wyness, who is the
4 Director of Social Services at the Ottawa Civic Hospital,
5 and Miss Irene Simard, who is a Director of Social
6 Services at the Ottawa General Hospital.

7 This delegation appears, Mr. Chairman,
8 in response to a letter which you forwarded to them
9 advising that the Commission is endeavouring to learn
10 more about the medical care and hospital services
11 received by the indigent and the medically indigent in
12 this city.

13 You also indicated that the Commission
14 would like to hear about the problems that the medically
15 indigent persons face in obtaining these services.

16 I understand that Dr. Laycock and the
17 members of the delegation are prepared to give whatever
18 information is required in this regard.

19 SUBMISSION OF THE WELFARE COUNCIL OF OTTAWA

20 Appearances: Dr. J. Laycock
21 Miss Enid Wyness
22 Miss Irene Simard

23 THE CHAIRMAN: Thank you, Dr. Laycock
24 and ladies for coming. We are interested in trying to
25 find out just what the state is of things in connection
26 with those who are unable for one reason or another from
27 their own resources to supply themselves initially with
28 medical services, perhaps health services in general.

29 To begin with, we speak of indigents.
30 Is there here some definition of that class? Are you
able to say just how the indigency is determined,



1 identified?

2 DR. LAYCOCK: Well, sir, we would look
3 upon an indigent person as one who is in receipt of
4 public assistance of some form or another, and this
5 would cover general welfare assistance, assistance from
6 the municipality or provincial public assistance programs,
7 old-age assistance, the blind, allowances for the
8 disabled.

9 These would be the major categories.

10 THE CHAIRMAN: Dr. Laycock, you were not
11 asked to have a prepared statement, but if you do have
12 one we would be prepared to have it.

13 DR. LAYCOCK: We do have a written
14 statement if you would like to have it at this moment,
15 if you would like me to comment on some of the points.

16 THE CHAIRMAN: You comment on it and
17 then you can give it to the Secretary and we can have
18 it mimeographed and sent to all members.

19 DR. LAYCOCK: I thought if I might
20 comment on it briefly. Miss Wyness and Miss Simard do
21 have cases which would cover the points.

22 THE CHAIRMAN: You use it in whatever
23 way you wish.

24 DR. LAYCOCK: I will comment on it if
25 I may.

26 We have looked upon a medically indigent
27 person to be an individual who is normally independent,
28 self-supporting, but who is unable to pay medical, hospi-
29 tal expenses under the conditions that are laid down for
30 free hospitalization.



1 This differs in various communities,
2 but there is a general classification here of a person
3 who is normally independent but who does fit into the
4 category laid down by the municipality.

2 5 We also draw attention to the more
6 loose approach to the medically indigent, not in the
7 sense where they can get free hospitalization and free
8 medical care but the middle-income groups who may face
9 severe medical expenses and who are, in fact, medically
10 indigent but they are not indigent as such.

11 In our approach we have a position in
12 that as far as hospitalization is concerned the indigent
13 and the medically indigent are not so badly off at the
14 present time; within these present categories hospitaliza-
15 tion is available to them.

16 Whether or not it is as freely available
17 to them automatically - I don't mean admission to hospital
18 for the medically indigent patients, but their attitudes
19 and their feelings of going into hospital may mean that
20 they delay going until their conditions are more serious
21 and more critical and are quite urgent; and although
22 we cannot offer documentary proof of this, I think this
23 is a negative factor in hospitalization.



1 We would feel too that in so far as some
2 of the medically indigent people are concerned, and
3 certainly for many of those in the middle income
4 groups, they too, if they haven't got full insurance
5 coverage, may delay applying for admission to
6 hospitals, or taking this matter up with their doctor
7 because of apprehensions or fear of the medical bills.

8 THE CHAIRMAN: Perhaps those of us who are
9 not from Ontario should have a better appreciation.
10 Just what is the position as regards entitlement to
11 hospitalization in Ontario?

12 DR. LAYCOCK: Any indigent person is
13 entitled --

14 THE CHAIRMAN: I mean the general public?

15 DR. LAYCOCK: Any medically indigent person,
16 whose resources in relationship to family size and
17 income, and is cleared for hospitalization by the
18 local authorities, is entitled to all the services of
19 a general hospital on a public ward, and this would
20 cover medical and surgical expenses too.

21 THE CHAIRMAN: I want to start from another
22 angle altogether. We are not talking about indigents
23 at all, just a citizen of the Province of Ontario.
24 What is the situation as regards hospitalization?

25 DR. LAYCOCK: Well, the insurance program
26 covers, I am not quite sure the full portion of the
27 general hospitalization of the province, but certainly
28 it is a very high proportion, and for these, of course,
29 hospitalization is available under the insurance
30 program.



1 THE CHAIRMAN: For which a premium is paid?

2 DR. LAYCOCK: For which a premium is paid.

3 Certain public assistance categories are paid for on
4 behalf of municipalities, as I understand it, if they
5 are long term cases, and if they are not so covered,
6 then if they have to go to hospital their hospitalization
7 is arranged through the local authority and the
8 hospital concerned.

9 THE CHAIRMAN: I understand the local
10 authority, the county or whatever form it may be,
11 they pay the premium for all the indigents of the
12 county?

13 MISS SIMARD: Indigents which are already
14 under welfare, relief, but you have indigents who are
15 not under welfare, relief, and for whom the premium
16 has not been paid by no one.

17 THE CHAIRMAN: Is there any compulsory
18 aspect to the payment of that premium?

19 DR. LAYCOCK: No.

20 MISS WYNESS: Only where the person is
21 employed in a firm with more than fifteen employees,
22 then it is compulsory on the employer. Where a person
23 is not in receipt of public assistance, and does not
24 have hospital insurance, then the municipality from
25 which that patient comes is required to pay the cost
26 of that hospitalization. In some of these cases the
27 municipality does pay a premium. Then it becomes part
28 of the premium program, but in other instances it is
29 under the Hospital Act and the municipality is required
30 to pay a portion of the hospitalization. The actual



1 difference between the cost under the Act and the cost
2 of the hospitalization is covered by the insurance
3 program.

4 DR. LAYCOCK: We feel too that with regard
5 to hospitalization that there are a number of services
6 very closely related to health, but spilling over
7 into the welfare field. One of the problems here is
8 providing suitable services for patients discharged
9 from chronically ill hospitals. In this city there
10 is no shortage of chronically ill hospital beds, or
11 beds for patients who have extended illnesses.
12 Problems do come up at the point of discharge, in
13 finding suitable living arrangements. Suitable
14 health facilities in terms of boarding home care, of
15 convalescent homes, of nursing homes, of institutions
16 for the aged, for the chronically infirm, and mildly
17 senile. These are services that are being improved
18 in this city, but there are gaps, limitations here,
19 which tend to disturb the proper flow of patients
20 from hospitals to other types of health care, or welfare
21 care in some instances, and more extensive services in
22 this regard we feel could help relieve pressure on
23 hospital beds, particularly in relationship to the
24 chronic patient.

25 We would also like, sir, to draw attention
26 to some of the advantages that might accrue in
27 relationship to the further development of home care
28 services, both community-based home care services,
29 where you have an integration of resources like
30 visiting nurses, visiting home makers, that can provide



1 the type of services that may enable the patient to
2 return to his own home, be adequately cared for, and
3 perhaps leave the hospital a little earlier, and
4 thereby too relieve pressure in hospital beds.

5 There is also a case for a hospital-based
6 home care program, where the patient is not
7 technically discharged from hospital, where he can go
8 home and the doctor, nurse or social worker if
9 necessary can follow into his home and provide
10 necessary services, and we feel that this is something
11 that might be certainly worthy of further exploration.

12 We would also like to draw attention to the
13 close relationship here between health services and
14 welfare services. From the point of view that unless
15 there is a good balance here, patients may not receive
16 the best follow-up service, and perhaps good medical
17 care may be in some sense lost, or wasted, or dissipated,
18 and we refer here to the strengthening of community-
19 based welfare services, including the environment
20 relating to the prevention and early identification of
21 illness, and here again questions of housing, and the
22 level of services available to families, where this
23 relates very definitely to the improvement of our
24 social welfare services in the community.

25 We draw attention also to the importance of
26 the rehabilitation services, recognizing that there
27 have been a lot of developments in this area, that
28 there are a fairly wide number of voluntary organizations
29 operating in this field, that both provincial and
30 federal governments have an interest in it, we feel it



1 needs a sharper focussed, that there is need for more
2 integration and cooperation between the voluntary
3 agencies and public authorities.

4 The rest of this statement, sir, apart from
5 one or two observations on mental patients, relating
6 also to the difficulties encountered in the re-establish-
7 ment of mental patients, and the need for more
8 integration in this respect, the rest of the statement
9 relates basically to short comings in medical care
10 services, focussed basically around the provision
11 of drugs, plus prosthetic appliances, dentures, eyeglasses
12 and some of the limitations in the provision for
13 medical care for indigents.

14 These are covered in this province, all
15 public assistance cases are covered under the medical
16 welfare plan. It is fairly broad coverage. It is
17 not fully comprehensive. It leaves some gaps, and
18 both Miss Wyness and Miss Simard have some case
19 illustrations relating to these facts pertaining to
20 drugs, dentures, eyeglasses and prosthetic appliances
21 where we feel that there are some very significant
22 gaps and weaknesses in the availability of services.

23 THE CHAIRMAN: Do you wish to give those
24 illustrations now, or do you say they have them as
25 written submissions?

26 DR. LAYCOCK: They are case illustrations.

27 MISS WYNESS: I have illustrations of the
28 problems relating to drugs. The first one is a thirty-
29 five year old widow with three children under public
30 assistance. This enables her to take her children



1 to the doctor, but there is no way to get drugs
2 prescribed by a private physician other than at a
3 drugstore. There isn't adequate allowance to take
4 care of the cost of drugs at this retail rate and the
5 hospital pharmacy isn't able to fill the prescriptions
6 of private physicians. It will fill those of
7 doctors on its own staff.

8 THE CHAIRMAN: Why, is there some --

9 MISS WYNESS: This is hospital policy. It
10 relates -- I don't know why, but it has not been
11 possible.

12 THE CHAIRMAN: There is no law against it?
13 It is a matter of policy, rather than prohibition?

14 MISS WYNESS: No, it is hospital policy.
15 The extension of hospital pharmacy to provide drugs
16 to private physicians would certainly involve the
17 Pharmaceutical Association, and this has not taken
18 place in this community. The provincial welfare
19 medical coverage does not include the drugs, but just
20 medical services, so that the only answer for this
21 woman was to bring her child to the out-patient
22 department, or the emergency department if after hours.
23 The child was seen again by a doctor and the doctor
24 again prescribed drugs in accordance with this
25 doctor's assessment, and these are provided by the
26 hospital pharmacy.

27 THE CHAIRMAN: Provided free?

28 MISS WYNESS: Free if for a person in
29 receipt of public assistance, but this involves getting
30 a sick child to the hospital, which poses many times



1 real problems, so that the gap of lack of drugs does
2 to some extent nullify this Ontario Medical Services
3 program that is provided to the indigent.

4 THE CHAIRMAN: That might be remedied if this
5 policy was changed, if the hospital pharmacy would fill
6 private physicians' prescriptions?

7 MISS WYNESS: Yes, the hospital already is
8 providing medical care to the indigents through its
9 own out-patient services. Whether it would extend its
10 services also to include private physicians, I think

11 ---

12 THE CHAIRMAN: In the social aid class?

13 MISS WYNESS: Yes, there would be no real
14 legal bar to this, but there would be certainly many
15 policy and practical problems involved. The doctors
16 whose prescriptions are filled at our hospitals are
17 on the hospital staff.

18 MISS SIMARD: We have the same problem in
19 our hospital. I don't know if we can call that a
20 legal objection, but if the hospital receives so much
21 per visit, it must be a visit to the hospital as far
22 as the law is concerned right now.

23 THE CHAIRMAN: That is a matter of payment?

24 MISS SIMARD: Right, so I don't know if the
25 amount is the same in every hospital, but I suppose
26 the procedure must be the same.

27 THE CHAIRMAN: If you gave away too many drugs,
28 you are going to have a deficit, a greater deficit?

29 MISS WYNESS: Yes, out-patient care certainly
30 isn't covered by the fee under the program.



1 THE CHAIRMAN: A dollar and a half?

2 MISS SIMARD: And the hospital has to
3 administer the whole clinic.

4 COMMISSIONER BALTZAN: Does that apply to
5 all the levels of public assistance, including the
6 old age recipients?

7 MISS WYNESS: The old age assistance
8 recipient is included, because this is a provincial
9 sharing program.

10 COMMISSIONER BALTZAN: When you say included,
11 they can get these drugs?

12 MISS WYNESS: Yes.

13 THE CHAIRMAN: But only at the out-patient
14 department?

15 MISS WYNESS: Yes, but this class of indigent
16 is also included in the provincial social assistance
17 medical services plan. The old age assistance person
18 is on a means test basis, and therefore already
19 determined to be indigent. The old age security
20 person, the over 70, must apply to be classified as
21 medically indigent, and therefore provided with this
22 service.

23 COMMISSIONER BALTZAN: And then they can
24 obtain that through the hospital pharmacy?

25 MISS WYNESS: No, only if they come to the out-
26 patient clinic can they get their drugs through the
27 pharmacy. They can go to a doctor under this Ontario
28 Medical Assistance Plan, but there is no way to get
29 drugs, other than from a drugstore on their meagre
30 pension.



1 THE CHAIRMAN: This woman with three children,
2 where did she get her drugs?

3 MISS WYNESS: She brought the sick child
4 to the hospital, with many problems involved in
5 getting to the hospital. The child was re-examined
6 and the prescription was made again by the doctor at
7 the hospital, so this is very wasteful of medical
8 services, as well as very poor practice.

9 THE CHAIRMAN: Are you getting the same
10 experience at your hospital, Miss Simard?

11 MISS SIMARD: That is right.

12 COMMISSIONER BALTZAN: Is it only by
13 prescription of a doctor in the out-patient department,
14 but not outside?

15 MISS WYNESS: Not outside the hospital.

16 MISS SIMARD: Not only that. Even if a
17 patient is a patient of the out-patient, and needs
18 only to renew his prescription he has to see his
19 doctor and have a new evaluation.

20 THE CHAIRMAN: Each time?

21 MISS SIMARD: Each time, whether needed or
22 not.

23 THE CHAIRMAN: So we would have to bring
24 the sick child back next week?

25 MISS SIMARD: Sure, if it is needed, but of course
26 if he doesn't necessarily need to see the doctor,
27 the hospital will make an appointment for the next two
28 or three weeks. The doctor's visit must take place,
29 and this is written in the Commission Regulations.

30 COMMISSIONER BALTZAN: I didn't know where



1 the stupidity was, whether it was here or in the
2 regulations, that is the reason for my questions.

3 MISS WYNESS: There is one other case I
4 have, which illustrates the problem of the person who
5 is not indigent, normally carries full responsibility
6 for the health care of his family, but this particular
7 medical problem is very serious. It is an obscure
8 condition. The drugs costs are out of all proportion
9 to what anyone under normal income circumstances could
10 support at all. This little two and a half year
11 boy has a disfunctioning of the pancreas, which
12 involves a very expensive pharmaceutical dietary
13 product, and the father paid between \$60.00 and
14 \$70.00 a month for this. This is to prevent mental
15 deterioration as part of this problem.



1 This family already have one child
2 whose condition was not diagnosed until the problem was
3 irreversible and they are trying very hard to prevent
4 the same thing happening with this little boy. After
5 the year the father thought he could not support this
6 because in addition to this special diet there are other
7 dietary needs this child has to have so we made arrange-
8 ments to admit this child to an out-patient department
9 although, strictly speaking, it is not the kind of family
10 eligible for out-patient care because the income was
11 something over \$6,000 a year.

12 This father, by prescription from the
13 out-patient department, now gets this product at cost.
14 This boy is developing very well, they are most hopeful
15 this child is going to be saved but this child must be
16 on this regime until he is seven.

17 Here is a medically indigent person in
18 a reasonable income bracket by reason of severity of
19 the medical condition. The other condition is a cystic
20 fibrotic condition and it gives us a good deal of work
21 to keep this child alive.

22 COMMISSIONER FIRESTONE: You say "at
23 cost"; what would this father pay?

24 MISS WYNESS: About \$25 a month.

25 COMMISSIONER FIRESTONE: \$25 as against
26 \$60 or \$70?

27 MISS WYNESS: Yes, it is an obscure
28 condition and there is not much call for this product
29 and it is not likely it is going to go down much.

30 COMMISSIONER FIRESTONE: Thank you.



1 THE CHAIRMAN: Do you have some cases,
2 Miss Simard?

3 MISS SIMARD: Yes, they are quite
4 different. There is a case of a prosthetic appliance;
5 we had an 84-year old gentleman who was suffering from
6 Parkinson's disease and he was admitted to our hospital
7 in October 1961. The treating physician referred that
8 patient to the social service department to provide for
9 an orthopaedic shoe because this man was suffering from
10 multiple deformities of the foot.

11 I think that some surgical intervention
12 has been tried and what was prescribed was the special
13 shoe. Being single, this man has been living, prior to
14 hospitalization, at the Union Mission, which is a home
15 for transient men. This gentleman was living with his
16 old-age pension and paying his way at this place, this
17 was his residence.

18 On receipt of the doctor's prescription
19 the social worker contacted the City of Ottawa Social
20 Service Department and asked that the prescribed shoe
21 be provided under the joint welfare assistance regulation.

22 This application must get provincial
23 Department of Welfare approbation in order that the
24 municipality covers 50% of the cost. The patient had
25 been kept in hospital because of this need for the shoes
26 but after a month-and-a-half waiting we have finally
27 discharged the patient without shoes.

28 THE CHAIRMAN: Although you kept him a
29 month-and-a-half?

30 MISS SIMARD: Yes, as the shoes had not



1 been provided we had to make a different arrangement
2 for this man who could not return to the home because
3 it was not a convalescent home, just a home for transients
4 and it was very poorly equipped for a sick man.

5 Many 'phone calls were made and, of
6 course, a lot of paperwork, to try to solve this problem
7 of discharge of this patient due to his old age, due to
8 his Parkinson's disease, but mainly due to the fact that
9 he had no special shoe to walk around and be a bit ambu-
10 lant.

11 The discharge of the patient had been
12 planned for custodial care. An application was made
13 through the Social Welfare Department through the
14 Department of Health who is looking after this type of
15 discharge plans and the patient was sent to one of our
16 out-of-town nursing homes.

17 The service was supposed to keep on to
18 follow the request for the shoes because the case is
19 then transferred, our service does not get involved.

20 However, as a matter of curiosity,
21 yesterday I made a 'phone call and the information is
22 that the shoes have not, as yet, been provided. This
23 request was filed in October 1961.

24 THE CHAIRMAN: Now, he is in a nursing
25 home because of the want of the shoes?

26 MISS SIMARD: Right, he needs to be
27 treated as custodial care.

28 THE CHAIRMAN: And was in hospital a
29 month-and-a-half longer than necessary for the same
30 reason?



1 MISS SIMARD: Right, so this matter is
2 very frequently happening and in applying for things of
3 this nature it is a long procedure.

4 COMMISSIONER McCUTCHEON: There is
5 nothing in the law that would prevent the City of Ottawa
6 from doing that?

7 MISS SIMARD: That is right.

8 COMMISSIONER McCUTCHEON: It is a
9 matter that they do not want to do it unless they are
10 sure they would only pay 20% of the cost?

11 MISS SIMARD: I would prefer that you
12 say so.

13 COMMISSIONER McCUTCHEON: Well, that is
14 the fact.

15 MISS SIMARD: Of course, we have lots
16 of case illustrations. I have a case illustration here,
17 a poor housing situation which is a terrible factor
18 contributing to illness.

19 This particular family, in October 1961,
20 was referred to the Ottawa General Social Service Depart-
21 ment by the treating physician who asked that the home
22 conditions be improved.

23 A female child, 8 years of age, was
24 admitted with an acute suppurative otitis media. The
25 mother is 26 and pregnant and sick, the father is 31
26 and out of work, having had an accident and is waiting
27 for compensation.

28 They have four living children and the
29 three children remaining at home are also sick and under
30 the care of the same physician but they can be taken care



1 of by the hospital.

2 The social worker assigned to our staff
3 contacted the public health nurse and also the local
4 Children's Aid Society in order that this family be
5 followed and the home conditions improved.

6 This agency felt that no payment was
7 required because they are good parents and so forth
8 but they are living under difficult conditions. The
9 family has been followed and in March 1962 they were
10 again referred to the Ottawa General Hospital Social
11 Service Department by the treating physician.

12 The last baby born is one month old and
13 is in hospital with pneumonia. The doctor spells out
14 the social problem:

15 "Enfants dans un taudis sordide.

16 Y a-t-il possibilité d'avoir de

17 l'aide pour obtenir une maison

18 à loyer modique?"

19 This means that the doctor spells out
20 the medical problem and spells out the social problem
21 which means that these people are living in a slum.
22 The agencies enumerated before have been following the
23 family during all this time.

24 We sent one of our workers for a home
25 visit and this visit was most distressful. This was a
26 real slum, the rent is \$65 a month and the house is
27 miserable and without a cellar.

28 At this time of year the shed's floor
29 and also the children's room and the kitchen are covered
30 with water varying from a few inches to two feet. This



1 house hardly dries even in the summer months. The walls,
2 ceiling, floor need repairing.

3 Prior to our home visit the Department
4 of Health also visited this family. This house is very
5 cold and the mother states that it costs \$12 weekly to
6 heat it as it is.

7 She is afraid to use the oil burner
8 because of fire. The social worker contacted the
9 agencies involved in the case and also helped the mother
10 to mobilize herself and to utilize her own resources.

11 The newly-born baby was discharged to
12 his grandmother in the meanwhile that home conditions
13 be improved. The mother has found another house where
14 the cost is \$65 monthly but it is heated, possesses a
15 nice bathroom and it has five rooms and this a palace
16 from their own point of view. The family will probably
17 move there at the beginning of next month.

18 This typical example forces us to
19 realize that community conditions have a definite bearing
20 on health and a need to improve welfare conditions is
21 requested if we wish to prevent the onset and recurrence
22 of disease. I think this is what Dr. Laycock was refer-
23 ring to.

24 Of course, we do not have everyday
25 houses with two feet of water on the floor but, neverthe-
26 less, there are terrible houses and these conditions of
27 pneumonia are a problem in children's wards because of
28 their poor housing condition in this community.

29 THE CHAIRMAN: You have told us of
30 these distressing conditions and we know they exist but



1 I want to relate them to physicians' services. In any
2 of these cases and any other cases in your experience,
3 does anyone suffer from want of a physician's services
4 merely through lack of money?

5 MISS WYNESS: I do not suppose we can
6 document this. The people in receipt of public assis-
7 tance do have a pink card which entitles them to see a
8 private physician in his own office or to call him to
9 the house.

10 Now, whether or not the individuals
11 have difficulty in getting a doctor, I am not in a
12 position to say.

13 THE CHAIRMAN: Have you had complaints
14 to that effect?

15 MISS WYNESS: We do not because they
16 are coming to the out-patient department. Probably a
17 family agency or children's agency might know but from
18 the hospital point of view we see the people who are
19 using the facilities of the hospital.

20 COMMISSIONER FIRESTONE: Presumably
21 they are coming to you because they have not been
22 getting service elsewhere; why else would they come to
23 you?

24 MISS WYNESS: Well, I am not in a
25 position to say why but I am saying that they do come.

26 COMMISSIONER FIRESTONE: In large
27 numbers?

28 MISS WYNESS: In large numbers.

29 COMMISSIONER McCUTCHEON: The figure
30 we had yesterday for out-patients was close to 50,000



people between the out-patient and emergency.

1 MISS WYNESS: It would be higher than that.

2 I do not have the figures. I can get them.

3 THE CHAIRMAN: It would be in the same order
4 or higher?

5 MISS WYNESS: It would be higher, likely.

6 COMMISSIONER FIRESTONE: And many of those
7 would have the pink cards?

8 MISS WYNESS: Yes, a good many of them are
9 people in receipt of public assistance of some kind.
10 There is this limitation to the pink card medical
11 program because they cannot get diagnostic procedures.
12 They cannot get medicines or any of these things that
13 are available to them from the out-patient department
14 as a free clinic patient.

15 COMMISSIONER McCUTCHEON: In other words,
16 if they are coming to you, it is not because they are
17 not getting medical service. It's because they are
18 looking for these additional things?

19 MISS WYNESS: As I say, I am not even in a
20 position to comment on that. I don't know. We don't
21 get people coming ---

22 COMMISSIONER McCUTCHEON: Your first
23 illustration you gave us very definitely established
24 that.

25 MISS WYNESS: That one case, yes. The
26 doctor saw the child. Prescribed medicine but they
27 couldn't get the medicine.

28 COMMISSIONER McCUTCHEON: She was under
29 physicians care and needed something over and above it?

30 DR. LAYCOCK: This is one of the limitations



1 of those with the pink card. There are limited
2 provisions for consultation, for specialists services
3 and the regular home-office visit is quite limited.
4 For these reasons they would come to the clinics.
5 Even though they may repeat some service from their
6 own family doctors.

7 THE CHAIRMAN: Now Dr. Laycock in your opening
8 statement you referred to people who stay away from
9 doctors, who do not go soon enough. If I remember
10 correctly what you said.

11 DR. LAYCOCK: Yes.

12 THE CHAIRMAN: Now are you able to expand
13 that or to give us any idea of the extent to which
14 that may be the situation? Now we know those who
15 have the pink cards are free to go.

16 DR. LAYCOCK: I mentioned sir that this
17 could not be documented. You get the illustrations
18 of this all along the line. It is not something that
19 affects only the indigent medical people.

20 COMMISSIONER McCUTCHEON: I don't like going
21 to the doctor.

22 DR. LAYCOCK: It can affect anybody but
23 because of the financial illustrations it may very
24 well affect lower income people to a greater extent
25 but one cannot be dogmatic about it because we get
26 people who come forward here quite readily.

27 I think one has to leave it pretty general
28 statement but one that probably has some bearing to it
29 but this is not peculiar to indigent groups.

30 MISS SIMARD: There are also categories of



1 indigents who do not have the pink card. Like, to
2 illustrate, this family with this man who is working
3 temporarily and sometimes is out of work for two or
4 three weeks and receives public relief but he does not
5 have a chance to establish himself as a pink card
6 holder and I think that in those circumstances those
7 families are not entitled to doctors' visits in their
8 home or to their family. The only resource they have
9 is to go to the hospital.

10 There are a lot of those people who have no
11 benefit. The doctor goes. As a matter of fact, that
12 doctor went but it is of his own free will.

13 THE CHAIRMAN: That family had a physician's
14 service?

15 MISS SIMARD: Yes, but this is not covered
16 by -- it's the free will of the doctor.

17 COMMISSIONER McCUTCHEON: Do you know of any
18 case Miss Simard where people have failed to obtain
19 the service of the physician merely because they don't
20 have the money to pay at the time or maybe any time?

21 MISS SIMARD: Well we cannot say that, because
22 they don't have the money if the doctor goes in any
23 case, you know.

24 COMMISSIONER McCUTCHEON: That is what I
25 mean. The doctor goes in any case.

26 MISS SIMARD: Although we have no -- I think
27 that is the social service department.

28 THE CHAIRMAN: This is really another agency?

29 MISS SIMARD: Yes. The same procedure,
30 but I know I have no case who is not referred by a



1 doctor so there must be a doctor to start with in order
2 that I would be there.

3 COMMISSIONER McCUTCHEON: You know of no
4 cases. These cases that come to you have already been
5 referred by a doctor?

6 MISS SIMARD: That is right.

7 MISS WYNESS: That is to the social service
8 department.

9 MISS SIMARD: You see we couldn't have figures
10 on those who do not have a doctor. It is difficult
11 for us to answer that.

12 THE CHAIRMAN: You are a hospital basis?

13 MISS SIMARD: That is right.

14 THE CHAIRMAN: Dr. Strachan?

15 COMMISSIONER STRACHAN: No questions.

16 MISS SIMARD: There would be another case
17 here, I don't know if you would -- about a convalescent
18 home. Would you like to hear that?

19 THE CHAIRMAN: Yes.

20 MISS SIMARD: This is also another need in this
21 community. A man of thirty-three years old has been
22 referred to our social service department from the
23 neurologic department with the medical diagnosis
24 of probable epilepsy. Prior to hospitalization this
25 fellow was from -- has been out of town and on his way
26 back to join back his family at the station he fell
27 down and injured himself. On this plan, on that fall
28 he has been first diagnosed as epileptic. Then under
29 the investigation in the hospital the epilepsy has been
30 ruled out. The treating physician asked to the social



1 service department to discharge this patient to a
2 place where he could rest, and secondly, where he
3 could be observed closely.

4 It is obvious that this fellow was in need
5 of a convalescent home to be discharged to, or to a
6 home which could provide him with convalescence. His
7 father was under public relief and he was also
8 miserable man with no financial means to take care of
9 the patient. His brothers and sisters were also on
10 public relief of some sort and this family was just
11 impossible to utilize for discharge of the patient.

12 Our worker had to get in touch again with
13 the City of Ottawa, social service department in order
14 to receive support. There is in this community an
15 organization the Information and Service Bureau I have
16 been referring to in the previous case, but they are
17 mostly interested in elderly people so we could not
18 discharge this man to a boarding home under their
19 supervision because this man is only thirty-three
20 years old. After many phone calls, many letters, many
21 inquiries and many, many pleadings we finally obtained
22 the cooperation of the City of Ottawa to pay for his
23 maintenance during the month period if we found a
24 boarding home on our own, so we did.

25 This gentleman was discharged and it happened
26 that he behaved very well. No more attacks of any
27 sort and the epilepsy has been ruled out.

28 Finally the gentleman has been encouraged
29 to go to the National Employment Service and he found
30 employment which was another way to help him to



1 rehabilitate and also to see under stress how he would
2 act. The epilepsy has been ruled out.

3 This is one of the many examples. If we
4 would have had a convalescent home to discharge this
5 patient to it would have been the normal easy procedure
6 to discharge this patient. I think this discharge
7 has been delayed by several days before we could
8 convince the City of Ottawa for cooperation and that
9 we have to plead a special case on each one.

10 They are quite cooperative. I don't want to
11 say that they do not cooperate but it is a special
12 case and each time it has to be pleaded individually
13 and then we have to find a boarding home and it is
14 not -- this gentleman had no attacks but if he would
15 have had an attack he would have been a danger because
16 they were not organized to take care of a sick man.
17 Finally it has been giving the gentleman what he needs
18 but I think this is a poor service.

19 THE CHAIRMAN: There is a lack of proper
20 convalescent facilities?

21 MISS SIMARD: Facilities. In this town it
22 means that on each patient we have to work out a
23 special solution and to each patient in a hospital it
24 is delaying the discharge and then we are short of
25 beds.

26 THE CHAIRMAN: Keeping an acute case out of
27 the hospital. Dr. Firestone?

28 MISS WYNESS: The City of Ottawa has a
29 convalescent home for women but no accommodation for
30 men.



1 MISS SIMARD: And then this is a home. It
2 is not a convalescent hospital.

3 MISS WYNESS: It is a home.

4 MISS SIMARD: Of course this is answering
5 certain needs of certain people to have a home but it
6 is not a hospital.

7 COMMISSIONER BALTZAN: Dr. Laycock, ladies,
8 I am very grateful to you and I am sure the members
9 of the Commission are very grateful to you for
10 having stressed more than anybody else one of the things
11 that has been troubling us and that is this great
12 over-lapping between what is sometimes called health
13 medical service and social health welfare needs and
14 your two illustrative cases, I think, cleared up a
15 good deal for us. In one instance somebody was
16 receiving all that should be gotten, health service,
17 medical, nursing, etc. but couldn't go because of a
18 pair of shoes.

19 Another instance one could by the age of
20 seventy become perfectly all right if there was a
21 proper kind of a diet. In other words, frequently
22 it is the shortcomings of the social aids that are
23 necessary for this individual health rather than
24 strictly on treatment. Is that what you are trying
25 to make out?

26 MISS WYNESS: I think my point is that health
27 and welfare problems are indivisible. I am a social
28 worker. I am not an economist. I am not prepared
29 to say what this should be.

30 These are fringe medical problems. We are



1 concerned because they concern more particularly
2 people who are unable to provide them for themselves.
3 I have another couple of instances of this fringe
4 benefit problem in relation to dentures and glasses.

5 Now this is a thirty year old deserted
6 wife, five children, coming into our out-patient
7 department because of pains in her stomach. She has
8 been thoroughly investigated. The pains in her
9 stomach are because she is not digesting her food.
10 She is not digesting her food because she has no
11 teeth and there is no provision out of public funds
12 to provide dentures for this woman.

13 This woman is physically suffering. She is
14 becoming shy and withdrawn. She has five children
15 dependent on her and if her health breaks down we have
16 got five children to care for. We are busy trying
17 to find voluntary resources to provide this necessary
18 ancillary health care.

19 The same way with eyeglasses. A seventy-three
20 year old man, independent as can be, living with one
21 of his married children. He is not eligible for
22 additional benefits to his old age assistance. A
23 friend died and left his glasses to this old man,
24 so he has been wearing those glasses and he has
25 reached the point they do not work very well. At
26 the clinic glasses were prescribed but where are you
27 going to get glasses?

28 I am lucky. At the Civic Hospital we have
29 a fund available from our Womens' Auxiliary and the
30 last ten months seventeen pairs of glasses have been



1 bought out of this voluntary fund. These are
2 fringe requirements to a comprehensive health program.
3 Whether they are provided for under welfare budget
4 or under a health budget I do not too much care.

5 In thinking about a comprehensive health
6 program these fringe areas, I feel, should not be
7 overlooked.

8 COMMISSIONER BALTZAN: Thank you for
9 supplying us with the fringe areas.

10 COMMISSIONER FIRESTONE: Dr. Laycock, I
11 have a questions to address to you. Please feel
12 free to call on the two very competent ladies to
13 supplement or offer any other answers that you wish
14 them to make.

15 Dr. Laycock can we start out by defining,
16 very briefly, the two groups that perhaps we will be
17 talking about. One is the group called the indigent
18 and they are covering people on public assistance,
19 and then we will talk of the medically indigent.
20 They are people that are not on public assistance but
21 maybe self-sufficient at one time and not self-
22 sufficient at another time but do need medical care
23 plus health care and I direct my questioning on the
24 basis of these two definitions to you, particularly
25 on public assistance recipients which we now have
26 defined as indigents in receipt of the pink card which
27 entitles them to medical care service.



1 DR. LAYCOCK: Yes, they are entitled to
2 free medical care services.

3 COMMISSIONER FIRESTONE: But are all
4 recipients of public assistance covered? Are there
5 public assistance recipients who do not get coverage?

6 DR. LAYCOCK: No, to the best of my
7 knowledge, all public assistance recipients are covered;
8 and in addition those people on old-age security who
9 have a card or had a card before reaching 70 years of
10 age.

11 MISS WYNESS: There are people receiving
12 public assistance because they are unemployed. This
13 group is not covered. It is the unemployable that is
14 covered by the program.

15 So the unemployed group is not covered.
16 Is that right?

17 DR. LAYCOCK: Yes, that is so.

18 COMMISSIONER FIRESTONE: So we distin-
19 guish two groups in the indigent group: those that are
20 the unemployables, the old, infirm, sick, and who are
21 issued these pink cards; then we have people that were
22 unemployed, received unemployment insurance and exhausted
23 the unemployed insurance and then were transferred to
24 public assistance, and those people are not in receipt
25 of a pink card.

26 DR. LAYCOCK: That is right.

27 COMMISSIONER FIRESTONE: Talking of
28 the people that are not in receipt of the pink card,
29 the unemployed, public assistance recipients; if he
30 gets sick and needs a doctor, what does he do?



1 MISS WYNESS: He comes to the emergency
2 department of the hospital generally.

3 DR. LAYCOCK: They could certainly, if
4 they have their own doctor, get in touch with their
5 own physician and receive his services, or they might
6 pay for the services, which is another matter.

7 MISS SIMARD: This case that was men-
8 tioned, this is a case which is not covered by anything,
9 and the physician was called by the patient and finally
10 referred to the hospital because that doctor is on the
11 hospital staff.

12 COMMISSIONER FIRESTONE: So if this
13 particular person has a regular physician he or she may
14 go to the physician? If he or she hasn't a physician,
15 then your answer is that the person could go to the ---

16 MISS WYNESS: The out-patient clinic
17 or the emergency department of the hospital if it is
18 after noon.

19 COMMISSIONER FIRESTONE: What happens
20 if the person has a child and the child is seriously ill
21 and cannot be moved?

22 MISS WYNESS: What happens is the mother
23 often calls the Police Department, the police arrange
24 for ambulance service and they are received at the
25 emergency, the ambulance service being arranged by the
26 police.

27 COMMISSIONER FIRESTONE: Is there not
28 an emergency service?

29 MISS WYNESS: That is a point I am not
30 entirely familiar with. I believe there is an emergency



1 medical service, but I don't know how it works.

2 COMMISSIONER FIRESTONE: We are
3 talking about a child being brought to hospital? Have
4 you had cases like this?

5 MISS SIMARD: Definitely people have to
6 be brought to the hospital by ambulance, but they have
7 to reach the hospital one way or another.

8 COMMISSIONER FIRESTONE: Would it not
9 be efficient if the doctor has been called rather than
10 get the police involved and getting an ambulance?

11 MISS SIMARD: Definitely.

12 COMMISSIONER FIRESTONE: Then can we
13 come on to the other services. Now, these indigents
14 that have a pink card are only entitled to medical care
15 services; they are not entitled, as I understood you to
16 say, Dr. Laycock, to drugs, dentures, dental service
17 and other fringe requirements of health services; is
18 that correct?

19 DR. LAYCOCK: Yes.

20 COMMISSIONER McCUTCHEON: They are
21 entitled to dental services, are they not?

22 MISS SIMARD: We extract them but not ---

23 MISS WYNESS: Extractions and out-patient
24 clinics.

25 COMMISSIONER FIRESTONE: Perhaps if I
26 may phrase the question. In the field of dental services
27 what happens if a person is in receipt of that pink card
28 and he has serious toothache? What does that person do?

29 MISS WYNESS: Comes to the clinic and
30 the tooth is extracted.



1 COMMISSIONER FIRESTONE: If the tooth
2 extraction is not necessary according to competent
3 dental advance, does the dentist treat according to
4 what his practice will be or does the law require him
5 to pull out a tooth even though in his judgment this is
6 the wrong thing to do? What does he do? There will
7 be cases where the dentist would say "This tooth
8 shouldn't come out" but the patient says "I am sorry,
9 Doctor, I have such pain it will have to come out."

10 MISS SIMARD: I wouldn't like to say
11 in any absolute fashion, but I don't think there is
12 provision for treatment of the teeth; there is provision
13 for extraction.

14 THE CHAIRMAN: There is provision for
15 relief.

16 MISS WYNESS: If there was medicine
17 required that would be applied and taken internally and
18 this might relieve the problem. The dentist might have
19 that resource available to him in the dental clinic.

20 In our hospital we are in the process
21 of developing a dental clinic, but we are hopeful that
22 just extractions are not going to be the only dental
23 service provided.

24 COMMISSIONER FIRESTONE: But if, if I
25 understand you ladies correctly, all the dentist can do
26 is extraction, and if in his judgment other treatment
27 would be appropriate, he is not permitted to do so?

28 MISS WYNESS: Not at the dental clinic.
29 If he wanted to take this person in his own time in his
30 own office, this he could certainly do.



1 COMMISSIONER FIRESTONE: On his own,
2 but if this person is a public assistance recipient,
3 has no money, it would be based on the dentist's charity?

4 MISS WYNESS: Mind you, this does happen
5 in our hospital; the charity of the dentist is strained
6 many times. But there is no provision out of public
7 assistance.

8 COMMISSIONER FIRESTONE: This speaks
9 highly of the dentist, but it doesn't solve the problem
10 you have been bringing to our attention.

11 May I turn to the other group, and that
12 is the provision of drugs. Have you run into a complaint
13 that the drug costs are high?

14 MISS WYNESS: Well, a very simple drug
15 is high to a person in receipt of public assistance.
16 A dollar out of public assistance income is high.

17 COMMISSIONER FIRESTONE: I am just
18 wondering whether you two ladies who deal with some
19 cases and see the public have run into comments from
20 people that come in to see you or speak to others in
21 your departments?

22 Have you come across any comments on
23 this subject?

24 MISS SIMARD: Definitely; but, of
25 course, we don't keep statistics of that.

26 COMMISSIONER FIRESTONE: We are not
27 talking about statistics, we are just asking for your
28 experience.

29 MISS SIMARD: On the high price of
30 drugs?



1 COMMISSIONER FIRESTONE: Yes.

2 MISS SIMARD: Definitely.

3 COMMISSIONER FIRESTONE: What do people
4 say about the high price of drugs when they have a
5 prescription to fill?

6 MISS SIMARD: Well, you have people who
7 cut on their food to pay for their drugs until they
8 become eligible to be taken inside hospital, or some
9 patients wish, even if they are on public assistance
10 and even if the out-patient's clinic is available to
11 them, they want to see their doctor, so they might have
2 12 to pay \$10 to \$15 a month on drugs, but they prefer to
13 keep their private physician and they cut on their food.

14 This is freedom of choice of the patients.

15 COMMISSIONER FIRESTONE: That is cutting
16 down on food and their health is affected?

17 MISS SIMARD: Certainly.

18 COMMISSIONER FIRESTONE: Talking about
19 the second group, that is the medically indigent - now,
20 a person who is employed, earning \$80 a week, everything
21 is fine, and then he loses his job and he is on unemploy-
22 ment insurance, he is not entitled to a pink card. What
23 does he do if serious illness strikes and he has no
24 insurance coverage, he can't afford to pay the medical
25 bills that may be involved as far as his child or himself
26 is concerned?

27 DR. LAYCOCK: Well, in a matter of
28 hospitalization, hospitalization would be given in a
29 case of that kind.

30 COMMISSIONER FIRESTONE: Sometimes the



1 patient may not know he needs hospitalization.

2 DR. LAYCOCK: If he had his own doctor,
3 and it is a question of a condition that would warrant
4 hospitalization, he could be advised by his doctor that
5 he could be admitted to public ward care and the hospita-
6 lization would be met.

7 In terms of medical care services out-
8 side of hospital, he has got a pretty indefinite status,
9 and unless he can rely on his own doctor for medical
10 services there is not too much he can draw on from public
11 resources.

12 MISS WYNESS: Other than the out-patient's
13 clinic at the hospitals.

14 COMMISSIONER FIRESTONE: Let's say the
15 doctor examines a patient and the patient says "I am
16 sorry, Doctor, I won't be able to pay your bill," and
17 the doctor says "Never mind, I will look after you. You
18 have a job, you might be able to pay later on," and then
19 he prescribes for pneumonia some expensive drugs, and
20 he says "I am sorry, I haven't enough money to pay my
21 rent, for the food," and the doctor says "I am sorry,
22 you will have to have this drug; pneumonia is quite
23 serious."

24 What would happen then?

25 MISS WYNESS: The doctor would refer
26 the patient to the out-patient clinic; he would say:
27 "I am sending someone; I think he has pneumonia," and
28 then arrangements would be made for him to be in by one
29 of the clinic doctors.

30 COMMISSIONER FIRESTONE: If he had



1 pneumonia ---

2 MISS WYNESS: He might be admitted; if
3 the doctor thought he should be admitted then the clinic
4 doctor would admit him and he would be under public
5 assistance, he wouldn't have his own doctor.

6 MISS SIMARD: That is the question;
7 the patient must reach the hospital.

8 COMMISSIONER FIRESTONE: It would be
9 another ambulance to bring him to the hospital and he
10 would be hospitalized, and in the case of pneumonia how
11 long would he stay there? A week, ten days?

12 MISS SIMARD: The doctor would best
13 answer that question. I don't know.

14 COMMISSIONER FIRESTONE: Let's say he
15 would stay for a week, just for discussion. What does
16 it cost a hospital to keep a patient for a week? About
17 \$20 a day?

18 MISS SIMARD: About \$20 a day.

19 MISS WYNESS: \$24-something, per diem
20 cost.

21 COMMISSIONER FIRESTONE: If it were to
22 cost \$24 and it took the patient ten days to get over
23 pneumonia, it would have cost the hospital \$240.

24 MISS WYNESS: That is a per diem cost,
25 plus the drugs.

26 COMMISSIONER FIRESTONE: In the case of
27 a patient where the drugs could have been purchased
28 locally or made available locally, he could have stayed
29 at home and the cost would have been considerably less
30 than \$240 in sending the patient to hospital just to get



1 drugs.

2 MISS WYNESS: No, he wouldn't be
3 admitted just to get drugs. If he were admitted at the
4 out-patient clinic he would be sent home, and many of
5 these pneumonia cases are treated in that way.

6 They are not admitted because they
7 need drugs, they are admitted because they need care.

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1 COMMISSIONER FIRESTONE: But I take it there
2 must be serious cases where you wouldn't want to send
3 a man home who might be treated at home if drugs were
4 available?

5 MISS WYNESS: I wouldn't want to go that far.
6 I think admission to hospital is for people who require
7 hospital care.

8 COMMISSIONER FIRESTONE: Dr. Laycock, a few
9 months ago we read in the papers the story of a boy who
10 needed a heart operation and through no funds the
11 parents were not in a position to pay for the medical
12 expenses involved. How was this problem resolved?

13 DR. LAYCOCK: There were one or two instances
14 where service clubs have come through with enough money
15 to meet full expenses. If travelling out of town, the
16 transportation, and the actual cost of surgery and so
17 forth has been met in a few instances by service clubs.
18 These are very rare as I understand it.

19 COMMISSIONER FIRESTONE: Are there possibilities
20 to turn to charity in cases where one cannot obtain
21 either, say the funds required for the cost of operation,
22 or dentures, or other requirements?

23 DR. LAYCOCK: It is not so much a matter of --
24 denture services are certainly not available, but so
25 many other services are available at some point in the
26 community, but it involves a lot of searching, a lot of
27 time through several voluntary organizations or service
28 clubs. There are certain limited public facilities
29 available, A voluntary organization isn't going to
30 move until they have sorted out what can be secured



1 through public authorities. In some instances the
2 public authority isn't going to move until it has seen
3 what might be available through voluntary organizations,
4 and this kind of inter-play, which does take place,
5 means delay, and it means a lessening of the efficiency
6 of I would say both services, from both public and
7 voluntary resources.

8 COMMISSIONER BALTZAN: Is there cardiovascular
9 surgery performed regularly in Ottawa?

10 DR. LAYCOCK: I couldn't answer that.

11 MISS WYNESS: Yes.

12 DR. LAURIER: Yes.

13 COMMISSIONER FIRESTONE: If I understand you
14 correctly, sir, you say that we have a public services
15 system to take care of medical and health requirements
16 for people of inadequate means, but that the system is
17 not complete, and that it is in part supported by a
18 charitable contribution from the public at large, and
19 you also say that the combination of both the public
20 system as well as private giving, while it does take
21 care of most of the problems, takes care of them with
22 some delay, duplication of facilities, and does not
23 necessarily always provide the most effective health
24 service for the people in the city of Ottawa with which
25 you are familiar. Is this understanding correct, sir?

26 DR. LAYCOCK: Yes it is.

27 COMMISSIONER FIRESTONE: Thank you very much.
28 You have been very helpful, Dr. Laycock and ladies.

29 COMMISSIONER McCUTCHEON: You have referred
30 to the people who are independent, but they want drugs,



1 and you suggested that they went without food. Have
2 you heard of any situation in the City of Ottawa where
3 people on public relief obtain rental over and above the
4 permissible allowance, and going without food and
5 clothing or something?

6 MISS SIMARD: There is a certain amount given
7 on public relief. There is an evaluation of what is
8 the maximum cost for the rent, so if the indigent is
9 paying a higher amount, and this has happened often,
10 they have to cut on the remainder of the allowances which
11 is allowed for food and clothing.

12 COMMISSIONER McCUTCHEON: And you say that
13 this has happened often?

14 MISS SIMARD: Often. Although recently I
15 think that that allowance for rent has been raised,
16 but nevertheless I think it remains.

17 COMMISSIONER McCUTCHEON: Dr. Laycock, let
18 me ask you another question. If you had your choice
19 between we will say providing free medical services
20 for everybody, or free drugs for everybody, or for up-
21 grading the standard of housing in the City of Ottawa
22 and its environments, on what would you place the
23 first priority?

24 DR. LAYCOCK: It is a difficult question.

25 COMMISSIONER McCUTCHEON: Well, you told
26 Dr. Firestone that these other things were being looked
27 after, albeit not too efficiently.

28 DR. LAYCOCK: Well, there are certainly many,
29 many gaps there. These questions are not, as I see
30 it, an exclusive one, one against the other, and certainly



1 it seems to me that there is a unity here in relationship
2 to health and welfare and environmental services, and
3 certainly housing by itself isn't going to solve the
4 problems of all people who need a better environment to
5 live in. There are many of these people with many kinds
6 of problems, including health problems, and housing is
7 needed in order to make good use of health and
8 welfare services. It seems to me that on the health
9 side itself that speaking generally that we tended to
10 build a not too effective system to care for the indigent
11 and medically indigent, and this has been related to
12 welfare programs, not fully to a comprehensive approach
13 to health services, and that there are a lot of factors
14 here that are difficult really to sort out, should they
15 relate to welfare, should they relate to a more
16 comprehensive approach to health services, and is it
17 logical to maintain this distinction between the indigent
18 and the medically indigent, and others, in relationship
19 to health services? Are not health services such that
20 they should be available, ideally at least, to every
21 person on the same basis? And where we do not look
22 upon certain people as requiring health services through
23 an indigent approach, or through a medically indigent
24 approach? Admittedly there are many problems here, but
25 are not the health needs of the medically indigent
26 the same, and require the same services, and if one
27 looks at this, then it strikes me that these should
28 be related to, eventually to a total approach to the
29 provision of health services where you lessen these
30 differences, and not increase them between the indigent



1 and the medically indigent. It is not answering your
2 question on the priority.

3 COMMISSIONER McCUTCHEON: No, it is not.

4 DR. LAYCOCK: On the priority, we feel very
5 deeply in this community about the need for better
6 housing for many low income families. I would say we
7 feel equally the need for supporting, services,
8 both health and welfare, so that if many of these
9 families on low income got into new housing they are
10 being helped to make the most effective use of their
11 house, and also their health and welfare problems.

12 COMMISSIONER McCUTCHEON: But I am suggesting
13 that it is almost impossible to solve some of their
14 problems in the environments they are in. That it is
15 important first to provide a new environment.

16 DR. LAYCOCK: I agree with that, that with
17 new environment they would be in a position to make
18 more effective use of what health services are now
19 available.

20 THE CHAIRMAN: Thank you very much, Dr. Laycock,
21 Miss Simard, and Miss Wyness. You will appreciate from
22 the discussion just how important we do regard the
23 subjects which we asked you to discuss with us this
24 morning, and we are very grateful to you for the help
25 that you have been to us.

26 MR. HALL: Mr. Chairman, Dr. Laycock has a
27 memorandum that he suggested he submit.

28 THE CHAIRMAN: Miss Simard, were you going to
29 file yours as well?

30 MISS SIMARD: Yes.



1 THE CHAIRMAN: And Miss Wyness?

2 MISS WYNESS: Yes.

3 MR. HALL: The three memoranda together will
4 be Exhibit No. 208.

5 ---EXHIBIT NO. 208: Three Memoranda.

6 ---A short recess.
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1 MR. HALL: Mr. Chairman, there are present
2 from The Children's Aid Society of Ottawa, Mr. Joseph
3 Verbruggen, who is the Head of the Protection Department
4 of the Society, Mrs. Pauline McDonald, Case Worker,
5 and Mrs. Suzanne Denyer, Supervisor of the Intake
6 Department.

7 They are here in respect to the same letter
8 referred to in the introduction of the previous
9 delegation, at the request of the Commission to learn
10 more about medical care received by the indigent,
11 medically indigent, and so forth.

12 I understand that Mr. Verbruggen and his
13 associates are prepared to give any information they
14 are able to.

15 SUBMISSION OF THE CHILDREN'S AID SOCIETY
16 OF OTTAWA

17 APPEARANCES:

18 Joseph Verbruggen

19 Miss Suzanne Denyer

20 Mrs. Pauline McDonald.

21 THE CHAIRMAN: Did you bring with you any
22 written memorandum, or do you prefer we have it on a
23 discussion basis?

24 MR. VERBRUGGEN: Just as you like sir. I
25 would like to make a brief statement, and we also have
26 a few case examples. Many of the things that we would
27 like to say are undoubtedly overlapping with whatever
28 Dr. Laycock and his associates had to say. This is
29 simply because the social agencies in a city like
30 this will be dealing with many of the fringe type of



1 clients, that were described in the earlier discussion.
2 There are fringe clients that were at one time with one
3 agency and at another time are being served by another
4 agency.

5 We are also not able, I think, to have any
6 very well thought out opinion on these matters. Again,
7 it is very much a matter of a day to day type of service
8 that we give, and we see these medical problems as
9 they arise.

10 However, our main focus is child welfare, as
11 you know, and the admission of our children into our
12 care if the parents are no longer adequate, but we
13 try to maintain parental adequacy and strengthen the
14 family life so as to prevent children from coming into
15 our care, and we do find that often the fact that
16 medical services, or some medical services are not
17 sufficiently available to our clients just helps in
18 the eventual breakdown of the families. Also, when
19 children do come into care, we are still coping with
20 certain medical problems. Although we are then able
21 to pay for medical services, it may simply be a fact
22 of medical services not being available. What I have
23 in mind is, for instance, the lack of in-patient
24 psychiatric services for children, the complete lack
25 of nursing facilities for severely hydrocephalic
26 children, and indirectly related to this is the
27 tremendously high expenses involved in dental services
28 for our wards, and again I suppose this may be related
29 to the fact that this is something that was neglected
30 before the child came into our care, and it also goes



1 back simply to the unavailability of teeth, as was
2 explained to you before, false teeth, dentures, glasses,
3 or simply drugs, to so many of the families and
4 children that are still functioning as a family unit.

5 One more thing sir, before we would like to
6 give you a few very brief examples, is the fact that
7 our agency is covering the whole of Carleton County,
8 and we find that services within the city limits
9 are rather different from the services that are
10 available, or are not available, to the residents of
11 the county outside the city limits.

12 COMMISSIONER McCUTCHEON: What kind of services
13 are you referring to?

14 MR. VERBRUGGEN: I think this refers to
15 all kinds of social services, but medical certainly.

16 THE CHAIRMAN: Have you any inter-provincial
17 implications here, because of the two cities being so
18 closely integrated?

19 MR. VERBRUGGEN: Yes, indeed.

20 THE CHAIRMAN: You mentioned it vis-a-vis
21 Carleton and Ottawa?

22 MR. VERBRUGGEN: Yes. We find that in certain
23 areas the Ontario side may be reluctant to give service
24 to a client who has recently come from Quebec. There
25 will often be insistence that this client be returned,
26 but on the whole I would think that perhaps if the
27 work of our workers were enough, we would get service
28 for a non-resident.

29 COMMISSIONER VAN WART: The Children's Aid
30 Society in New Brunswick, for example, is an organization



1 which works entirely with families that have gone
2 through the courts. Is your work limited to that sphere
3 of action, or are you outside of the courts?

4 MR. VERBRUGGEN: We do sir. We have to go
5 to the court if we take a child into our care. This
6 can only be done through legal sanction of course.
7 However, before a child comes into care, we work
8 extensively with families, in order to strengthen, we
9 rehabilitate the family, to prevent the child coming
10 into our care, and this family work is done entirely
11 outside the court.

12 COMMISSIONER VAN WART: In New Brunswick, as
13 I understand it, the Children's Aid Society only
14 deals with those referred by the Courts. That is not
15 your case?

16 MR. VERBRUGGEN: No, we can be involved with
17 any child that is referred to us by any organization.

18 THE CHAIRMAN: Which comes to your attention?

19 MR. VERBRUGGEN: Which comes to our attention.

20 THE CHAIRMAN: You had some case examples to
21 tell us about?

22 MRS. DENYER: These two cases are county
23 cases which did rather aggravate the difficulties in
24 getting help. A family M, we have a mother, five children
25 of school age with the father in prison. The income
26 was mother's allowance, \$165.00, plus family allowance,
27 \$34.00, making a total of \$199.00.

28 The mother was suffering from three different
29 areas of health: a thyroid difficulty, epilepsy, and
30 problems with the uterus. Because of public



1 assistance she had a card to have medical care from
2 any doctor that she had named on the card for normal
3 ailments, for herself and her children. She had
4 to get special treatments for these three areas, and
5 she had to attend three different clinics and have
6 three different types of pills. The hospitalization
7 was paid by public assistance. The drugs, and cost
8 of clinic were covered by public assistance, and there
9 were several extras.

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1 Then father returned home and we get
2 a low income family about \$180 a month, family allowance
3 \$34, which is \$214 altogether.

4 The clinic is still available. I should
5 mention, of course, we also have got an extra adult to
6 feed and clothe and a man whom we are trying to rehabili-
7 tate.

8 The clinic is still available to the
9 mother but the drugs will have to be paid for unless
10 we, you know, become very bull-headed. Normally they
11 are expected pay for their drugs because they are an
12 income family.

13 The doctor, for any ailment in the
14 house, has to be paid and, of course, the hospitalization;
15 they have to pay for this. Now, he has not been able to
16 get the three months in advance he has to pay to get
17 into hospitalization and at the moment we have two
18 children needing a tonsilectomy and the mother needing
19 to have a hysterectomy.

20 These might be able to wait while we
21 get into hospitalization but it is the cost that they
22 cannot reach now. It is the pressure too that we are
23 concerned with to this man whom we are trying to keep
24 back in the community.

25 The other family, Family F, we had
26 five children admitted to care over three years ago
27 because - I should point out I am trying to say that,
28 you know, those on public assistance may be very poorly
29 off but not so badly off. You do get some help on low
30 income.



1 Five children admitted to care three
2 years ago because of mother's ill health, psychiatric
3 ill health, psychiatric ill health and the father
4 broke under the pressure of the mounting cost of the
5 illness. His income was only \$140 a month plus family
6 allowance and one child had bronchial problems which
7 meant calling in a doctor to see him because, you know,
8 he needed this attention.

9 The mother was under psychiatric care.
10 This was possible in the hospital but it was too expen-
11 sive on the out-patient basis. She would begin but,
12 you know, at \$15 a shot, they found this becoming too
13 expensive.

14 The debts amounted to \$3,000 when we
15 were first involved with them out of which \$250 were
16 for drugs and \$850 were for doctors and hospitalization.

17 The children were not able to return
18 home. All these children were quite awhile in our care
19 on our per diem rate which cost about \$65 each a month
20 to the assistance. They were not able to return home
21 because of the pressure of this debt plus continuing
22 ill health and because they were not able to get into
23 better housing in order to have these children returned
24 to them.

25 Since this last seven months the man
26 has become a civil servant. While he has a small income,
27 about \$178 a month, there is still the difficulty of ill
28 health but he is in a medical scheme and he does have
29 hospitalization so we have been able to begin rehabilita-
30 tion of these children because of these two things which



1 are available to the family.

2 Exactly the same kind of personalities
3 but because of these helps from the medical scheme and
4 the civil service and the hospitalization that he is now
5 able to be in, we can look forward to putting his family
6 together.

7 Shall I go on with this brief?

8 MR. VERBRUGGEN: Yes.

9 MRS. DENYER: This is a brief prepared
10 by the Child Care Department and she has pointed out
11 some needs that they see in their department. One of
12 the needs they feel is for further hospital care for
13 children not needing any specialized nursing but still
14 not able to be back in their own homes.

15 In some cases we have provided this
16 care through our foster home program as the parents
17 concerned were not able to give the intensive care
18 required due to responsibility of other children,
19 cramped living quarters, etc.

20 Now, there was no real neglect here
21 which is the only reason we do admit children for care
22 but because there was not available a good convalescent
23 home they were not able to be there.

24 We had a case of a five-year old child
25 hospitalized from July 1958 to May 1960 following a car
26 accident which resulted in some permanent disability
27 in speech and motor activity.

28 Hospital bills totalled some \$6,000.
29 The parents were Canadians by birth but legal residents
30 of the United States and had just returned to Canada at



1 the time of Ann's accident.

2 Inability to plan properly, non-residence
3 and low income were factors involved in lack of Ontario
4 Hospital Insurance.

5 Ann's hospitalization was prolonged
6 because of non-existence of adequate facilities in the
7 community to care for a child so handicapped. There
8 was nowhere else for her in the community. Institutions
9 in the Province have long waiting lists but apart from
10 this it was important to maintain the ties with family
11 and parents - were in no position to finance visiting
12 outside the area.

13 Fortunately, the Children's Aid Society
14 were able to locate a suitable foster home but this
15 meant a further two-month period of hospitalization,
16 until this was obtained.

17 This needs a special kind of foster
18 mother to offer this kind of care. I might point out
19 it also means extra payment for a foster home of this
20 type.

21 Ann, in the interim, could have bene-
22 fited by an institutional placement, which would have
23 provided schooling, further psychiatric and psychological
24 work-ups, physiotherapy, etc.

25 The time and cost involved, not only
26 in extended hospitalization but also in the work of
27 co-ordinating all these facilities in the community,
28 represented a staggering total in expenditure and man
29 hours.

30 Nursing home care is needed for very



1 badly damaged infants, suffering from extreme cases of
2 hydrocephales or spinabifiva. Five such cases were
3 admitted as infants in the normal procedure during the
4 past year and several less severe cases.

5 In all of these five cases life expect-
6 tancy was short. All these children had to be placed
7 in foster homes as the hospitals could not keep them
8 for any prolonged period and there was no other place
9 for them.

10 Three children remained in foster homes
11 until their deaths; one was admitted to Ontario Hospital
12 School at the age of three months and has since died.
13 One is still living. This is an extremely difficult task for
14 foster parents to assume, and it is extremely difficult
15 to find foster parents who will.

16 Four of the above children were children
17 of unmarried parents who would, in all probability, come
18 into our care as the mothers, prior to the infants'
19 deaths, had not any plan for them.

20 The fifth was a child of a marriage.
21 The parents had three other children at home, were
22 physically and emotionally completely unable to bring
23 their baby home from hospital and give him the type of
24 care he needed.

25 There is also emphasis here placed on
26 the extreme amount of funds that we have to spend on
27 these children when they come into our care for dental
28 care and also physical problems that have not been
29 taken care of when they were with their parents because
30 of lack of facilities.



1 We have even - maybe I should not say
2 this - kept a child in care a little longer in order
3 to make sure that he gets his dental work complete or
4 he gets something completed before he goes home because
5 we know once he goes home there is nobody to pay for it.
6 While he is in our care somebody will pay for it and
7 this is, you know, a pretty poor show.

8 COMMISSIONER McCUTCHEON: I think you'd
9 better not tell the Department of Health and Welfare
10 about that.

11 THE CHAIRMAN: I suppose you have got
12 to leave a lot to your judgment.

13 MRS. McDONALD: I have two situations
14 I want to present. One is the J. family. They are a
15 married couple with six children ranging in age from 9
16 to 1. Mrs. J. came to the agency with her sister
17 requesting the placement for her six children on the
18 basis that her physical health, and it was obvious her
19 emotional health had deteriorated to such a point she
20 could no longer take care of the children.

21 Now, Mrs. J. had no family doctor. Her
22 husband is a labourer and he earns about between \$200
23 and \$240 a month. We referred Mrs. J. to her sister's
24 doctor and her sister was going to pay the visit.

25 Now, she went to the doctor. The doctor
26 diagnosed that she had - she was in an acute anxiety
27 state. He prescribed medication for her, drugs. She
28 couldn't have the prescription filled. She didn't have -
29 the cost was too great. She didn't have the money.

30 Consequently, a period of about four or



1 five days elapsed. She got progressively worse. She
2 threatened suicide. We made a call to the doctor and
3 he said that it would be better if Mrs. J. was hospita-
4 lized as she seemed to be unable even to follow the
5 recommendations, the medical recommendations of the
6 doctor.

7 She was saying "If I have the prescrip-
8 tion filled, I will take an overdose of it" and there
9 would have been drastic consequences there.

10 He suggested Mrs. J. be sent to the
11 hospital by ambulance. We could not follow through
12 with this suggestion because there was no money available
13 for an ambulance.

14 What happened is that Mrs. J. went to
15 the hospital to the admission department. There was a
16 waiting period at the clinic of hours. She acted up.
17 She kicked some of the equipment and finally she was
18 admitted after two days of this going back and forth
19 from one clinic to another.

20 Now, we feel that if this person had
21 been helped with medication at the time that she needed
22 it, if she had been able to see the doctor, have a
23 family doctor and be able to pay for a family doctor,
24 probably we would not have had to admit six children
25 which we had in care for a period of three months.

26 I am glad to say that once she was in
27 the hospital they were covered with the Ontario Hospital
28 Plan and she did get adequate care and the family is
29 rehabilitated. Now, I have another situation where the
30 mother - this is also an Ottawa resident family. This
is the L. family.



1 Mr. and Mrs. they are a married couple and
2 there are four children ages seven, six, four and two.
3 Mrs. L. is pregnant, a four month pregnancy and she
4 had all her teeth pulled except five. The public
5 health nurse is saying that this woman's health is
6 very seriously affected because there are no dentures.
7 The chewing of the food causes indigestion and other
8 problems. Mr. L. is unemployed and has been since
9 last December and he lost his job because of debts and
10 his wages were garnisheed. When we look at the
11 financial picture, he owed \$508.00 of which more than
12 half of the amount is for medical debts. This man
13 was placed on Unemployment Insurance and the city
14 relief supplemented the Unemployment Insurance.

15 Now Mrs. L is at this point in need of teeth
16 and is asking for this service.

17 This man became employed, therefore, there
18 are no resources except the service clubs to provide
19 these for this woman. I think those are the two
20 situations.

21 COMMISSIONER McCUTCHEON: Who garnisheed his
22 wages?

23 MRS. McDONALD: One of the credit agencies
24 in the city. The medical debts had been pooled and
25 taken over by a credit agency and they garnisheed his
26 wages. There was a doctor's bill of \$216.00 and a
27 hospital bill of \$18.00.

28 COMMISSIONER McCUTCHEON: Those are the
29 debts for which the garnishee was issued?

30 MRS. McDONALD: That is right.



1 THE CHAIRMAN: Is there much of this matter
2 of medical debts being sold or assigned to credit
3 agencies?

4 MRS. McDONALD: Oh yes, very much so. After
5 a period of between three and six months a doctor will
6 pool his bills with a credit agency.

7 THE CHAIRMAN: Is that a matter of a collection
8 agency or does he sell the bill?

9 MRS. McDONALD: He has to pay a certain
10 percent to the collection agency to collect his bills.

11 THE CHAIRMAN: As you may have heard, there
12 was considerable discussion in the legislature
13 yesterday over a program in Toronto that apparently the
14 Minister of Health was not looking upon with much
15 favour, in any event.

16 MRS. DENYER: Once they go to the credit
17 agency it is an impersonal thing, they have a set way
18 of looking after it. If it remains with the doctor
19 he can discuss it with the family but once it has gone
20 to the credit agency it is gone.

21 THE CHAIRMAN: There is no one much tougher
22 than the collection agency?

23 COMMISSIONER STRACHAN: When the wages are
24 garnisheed, I do not know if we have the facts, but
25 have you any idea if the individual went to his medical
26 man and told him exactly the situation he was in --
27 was the medical man pushing for payment?

28 MRS. McDONALD: This was a doctor bill of
29 \$216.00 and it was for pregnancies; there are four
30 children so what has happened is that the bill has



1 accumulated. Now, I do not know whether the man did
2 go and ask the doctor and explain his situation but even
3 if he does, all he is relying on is the sympathy of the
4 doctor and, of course, the other thing is that he
5 cannot offer any plan, he cannot say "I cannot pay you
6 right now, but I will be able to pay you in six
7 months" because in six months the situation will be
8 the same.

9 COMMISSIONER McCUTCHEON: What were his wages
10 before he was dismissed?

11 MRS. DENYER: I think these are inadequate
12 people, they think that if they do not look at
13 something long enough it will go away. They do not
14 go at the right time, they do not come to us at the
15 right time. Certainly a doctor is something far
16 beyond their approaching to say "I am broke". Very
17 few of them would do this and I am sure if they did
18 they would get a sympathetic hearing occasionally.

19 MRS. McDONALD: I do not know how much he
20 was making.

21 COMMISSIONER STRACHAN: I am sure if the
22 physician realized that the wages were going to be
23 garnisheed and he would lose his job that he would
24 hesitate to do that.

25 MRS. McDONALD: Except this is what happens;
26 once the doctor has pooled his debts with the credit
27 agency the collecting agency goes ahead and if you
28 call the doctor the doctor has to say "I am sorry, I
29 cannot do anything about it now". Usually what
30 has happened is that if the doctor has been sending



1 bills to this family over a period a three or four
2 months he might be somewhat angry that these people
3 are now asking that the garnishee be lifted. He will
4 say "Well, the person has not acknowledged at any time
5 the matters of the bills received and I am paying for
6 the service of the collection agency, ergo, I am not
7 going to stop them doing their work."

8 MR. VERBRUGGEN: These clients are often not
9 the brightest ones. We find they are dependent on us,
10 to begin with, and we find it difficult for them to
11 speak for themselves.

12 MRS. McDONALD: Some of the work that has
13 been done on this particular family is a worker at the
14 agency has interpreted to the employee this man lost
15 his job in December, and apparently it was a rule of
16 this particular firm that if a garnishee was sent that
17 the person automatically loses his job. This is what
18 happened. Now, they have, this week, taken this man
19 back with the assurance of the worker, as much as she
20 can, to the employer that the person's wages will not
21 be garnisheed. Now, what we will be doing is pooling
22 accounts and sending a letter to each creditor asking
23 them to withhold any action until we can help this
24 family rehabilitate itself and maybe even give a
25 dollar a month toward their debts.

26 THE CHAIRMAN: The situation, of course,
27 that is in our primary field of interest is the health
28 services field. We know that there is an inter-
29 relationship between that and the field of the children's
30 aid and social work and so forth. However, by and



1 large, people when they need medical services get
2 them whether they pay for them or not or do you find
3 that the profession refuses services for want of money?

4 MR. VERBRUGGEN: Not by and large. I think
5 by and large people get services, it may be after a
6 long period, it may be after a painful type of
7 involvement far too late but they do get them
8 eventually.

9 THE CHAIRMAN: Are you suggesting they get
10 the run around?

11 MR. VERBRUGGEN: Yes.

12 THE CHAIRMAN: In what way does that work?

13 MR. VERBRUGGEN: Well, in relation to, for
14 instance, --

15 THE CHAIRMAN: I mean, if they phone the
16 doctor's office, make a direct approach, I take it
17 they get the service if the doctor is available, if
18 he is in town; if he is not actually doing something
19 else at the moment, he cannot do two things at once.

20 MR. VERBRUGGEN: But if the family is not
21 able to pay for his services he will attend to them
22 the first time and the second time, but after that it
23 becomes his own dealings as to whether or not he will
24 serve these clients for free.

25 THE CHAIRMAN: Have you any indication in your
26 work that having gone once or twice the doctor gets
27 fed up and say "I cannot come any more. I do want
28 you in my office any more." Any indication of that?

29 MRS. DENYER: There are several doctors
30 who will not accept the public assistance cards. If



1 you draw public assistance or mother's allowance you
2 are given a card and you are able to name your own
3 doctor. The family before going on this public
4 assistance may have had a doctor who was their family
5 doctor but now when they get the card they go back
6 to him and ask him "Could we put your name on this?"
7 and there are quite a few doctors who refuse this.

8 THE CHAIRMAN: Is it because of what is being
9 asked is outside their specialty or something of that
10 kind?

11 MRS. DENYER: It could be, but I cannot but
12 wonder whether it is --

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1 THE CHAIRMAN: I mean, if that is what
2 the orthopaedic surgeon is being asked to look after.

3 MRS. DENYER: No, I am talking about
4 G.P.'s, general practitioners. That is what we use
5 most, general practitioners, and there are a few doctors
6 who really do, they just take all these. But there are
7 doctors who refuse to have their names on it. There is
8 no choice to the people really; they have a limited
9 choice.

10 THE CHAIRMAN: They don't accept
11 patients who have a pink card?

12 MRS. DENYER: That is right.

13 MRS. McDONALD: I have experience of
14 married women who were pregnant, and one went to see
15 the doctor; her husband wasn't the father of this child.

16 Now, the doctor said "I will see you
17 through for this one but don't come back". Now, this
18 person is ---

19 THE CHAIRMAN: He didn't want that
20 type of thing repeated?

21 MRS. McDONALD: I don't know whether
22 it is a moral judgment. Now, this person is in the
23 same condition again and she approached the doctor and
24 he said "I am sorry, no."

25 MRS. DENYER: I think what we said this
26 morning on the whole is that there are special care
27 services we would like to see in the community, such as
28 convalescent homes for the children.

29 I think we would like to emphasize these
30 things. It would be better to cost the community in a



1 right place rather than through a weird manner. It
2 should be costed in the convalescent home or nursing
3 home. There is also what you heard in the other brief,
4 the dentures, the glasses.

5 THE CHAIRMAN: We are concerned with
6 the lack of physician services.

7 MRS. DENYER: I would say personally
8 there is a very poor response to calls, when they call
9 a doctor. Also the doctors have to make an income, I
10 guess.

11 THE CHAIRMAN: They get paid when they
12 have these cards.

13 MRS. McDONALD: A small fee, but it is
14 not very much.

15 THE CHAIRMAN: You feel there is a reluc-
16 tance on the part of the profession to take on a ---

17 MRS. McDONALD: They have a choice to
18 refuse, and they do.

19 MRS. DENYER: It is very difficult to
20 take on an inadequate client. You have him and you
21 examine him and you tell him this is what is wrong with
22 him, this is what he needs, and he will walk out and
23 not do it.

24 THE CHAIRMAN: I understand that, but
25 I am just wondering about the practice of the physician
26 saying "I exclude from my practice anyone who has these
27 cards."

28 MRS. McDONALD: It is deplorable, but
29 it happens.

30 MRS. DENYER: But they have a right to



1 do this.

2 THE CHAIRMAN: They have a right to do
3 it. I am wondering about the incidence of it.

4 MRS. DENYER: I have had clients go
5 on public assistance and they say - this is somebody
6 who had attended them before - "I don't take these. I
7 make a rule of not accepting these."

8 THE CHAIRMAN: This is opening up a
9 subject we have not had before.

10 COMMISSIONER VAN WART: The doctor who
11 does not take the pink card patients, has he had some
12 bad experience with the pink cards before that?

13 MRS. DENYER: I have never really
14 discussed it. My understanding is that they are too
15 busy, they don't have time. Again, I am not standing
16 up for the doctors, but very often these are people who
17 have seven or eight children, and if you take their
18 pink card you are going to be a very busy doctor.

19 I don't think that is an excuse for it,
20 but very often it is a reason.

21 COMMISSIONER VAN WART: In other words,
22 they can only attend one patient at a time?

23 MRS. DENYER: Yes, they are too busy.

24 COMMISSIONER VAN WART: Then the doctors
25 that are not busy, do they refuse the pink cards as a
26 rule?

27 MRS. DENYER: There are one or two who
28 have got used to dealing with these people, and I know
29 one or two doctors in Ottawa who have always served
30 this type of family, and part of it is a feeling of need



1 for their services and also enjoy working with this type
2 of family, it gives them satisfaction.

3 COMMISSIONER McCUTCHEON: A doctor
4 with that feeling will give better care than one with
5 equal or better ability but lacking in sympathy?

6 MRS. DENYER: Yes.

7 COMMISSIONER VAN WART: Are these
8 young doctors?

9 MRS. DENYER: We don't know that.
10 We just work from day to day with our clients.

11 COMMISSIONER VAN WART: But you do say
12 the busy doctor has a tendency to refuse the clients?

13 MRS. DENYER: There are fewer G.P.'s
14 now. Practically every doctor that comes out now seems
15 to specialize. You don't have so many general practitioners.

16 COMMISSIONER VAN WART: Do the general
17 practitioners refuse these cards?

18 MRS. DENYER: These are the ones we
19 need.

20 COMMISSIONER VAN WART: And they accept
21 the cards?

22 THE CHAIRMAN: It is the general practi-
23 tioner who has refused the cards.

24 MRS. McDONALD: We also have another
25 problem that I have run into in this situation where a
26 general practitioner had diagnosed or suggested the
27 patient be admitted and you, while you have a diagnosis
28 and you have the hospital saying this is just a general
29 practitioner's opinion.

30 Now, if that person had been seeing a



1 private physician or a specialist, obviously the diagnosis
2 would have more weight than coming from a general practi-
3 tioner.

4 COMMISSIONER VAN WART: May I ask
5 another question? Do some G.P.'s who have been under
6 the scheme withdraw when they get busy under the scheme?

7 MRS. DENYER: Once they accept the card
8 they stay with it.

9 COMMISSIONER VAN WART: Once they
10 accept?

11 MRS. McDONALD: Yes.

12 MRS. DENYER: I would like to say that
13 it bothers me a little bit to criticize the general
14 practitioner because of our feeling for some doctors in
15 Ottawa who do very special and heartwarming work with
16 these people. I would hate to say these are people who
17 won't take the card.

18 COMMISSIONER VAN WART: Is it the
19 Canadian doctor who refuses the card or is it the doctor
20 who has come from abroad?

21 MRS. McDONALD: My experience is that
22 it has been the Canadian doctors.

23 THE CHAIRMAN: Thank you very much,
24 Mr. Verbruggen, Mrs. Denyer, Mrs. McDonald. We learn
25 something new every time, we hear something new. It is
26 because we want to cover the whole field that we want to
27 hear from organizations such as yours, and we are very
28 grateful to you for having accepted the invitation
29 extended to you, and you have been very helpful.

30 MRS. DENYER: Thank you.



1
2 THE CHAIRMAN: Now, this concludes our
3 public hearings here in Ottawa.

4 I take it there is no one present who
5 wishes to be heard?

6 As I say, this concludes our public
7 hearings, and we will resume in a private meeting at
8 Room 400 in the Daly Building at 2 o'clock.

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10 --- Adjournment.

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ROYAL COMMISSION ON HEALTH SERVICES

ENGLISH VERSION

HEARINGS

HELD AT

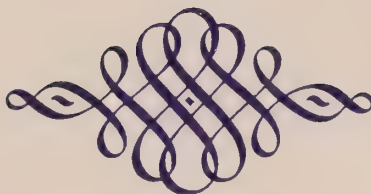
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CONTINUED

EXHIBIT A

Ottawa, Ontario

Page 788, line 28

Should read: "content of 0.10%" instead of:
"content of .01 per cent".

Page 788, line 13

Delete quoted portion and insert:

"Directed the Secretariat to convey to the Minister of Justice the recommendation in the 1961 report of the Committee on Medical Aspects of Traffic Accident requesting amendment of the Criminal Code to permit, as legally admissible evidence of impaired ability to drive a motor vehicle, the blood alcohol levels defined in the Committee's report. The Executive Committee further proposed that this recommendation be incorporated in the C.M.A. brief to the Royal Commission on Health Services."

Should read: "May 1955" instead of: "May 1953".

Page 789, line 13

Should read: "the leading cause of loss of life years in this country today is the result of accidents" instead of: "the leading cause of life



VOLUME 40

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(LES SERVICES DE SANTE DU
QUEBEC)

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LA CONFÉDÉRATION DES SYNDICATS
NATIONAUX

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CONTINUATION OF HEALTH SERVICES
OF QUEBEC

7903

ERRATA

(Volume No. 38, March 26th, 1962,
Ottawa, Ontario.)

Page 7664, Line 26

Should read: "content of 0.10%" instead of:
"content of .01 per cent".

Page 7669, Line 13

Delete quoted portion and insert:

"Directed the Secretariat to convey to the Minister of Justice the recommendation in the 1961 report of the Committee on Medical Aspects of Traffic Accidents requesting amendment of the Criminal Code to permit, as legally admissible evidence of impaired ability to drive a motor vehicle, the blood alcohol levels defined in the Committee's report. The Executive Committee further proposed that this recommendation be incorporated in the C.M.A. brief to the Royal Commission on health Services."

Page 7687, Line 23

Should read: "May 1955" instead of: "May 1959".

Page 7689, Line 13

Should read: "the leading cause of loss of life years in this country today is the result of accidents" instead of: "the leading cost of life

/contd...



ERRATA (contd)

in this country today is the result of accidents".

Page 7690, Line 28

Should read: "medical profession cannot evade its responsibility" instead of: "medical profession cannot take this responsibility".

Page 7691, Line 12

Should read: "chemical" instead of "clinical".



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TORONTO, ONTARIO

ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing held
at Quebec City, Monday, April
9th, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

Miss ALICE GIRARD, R.N.

Dr. DAVID M. BALTZAN

Prof. O.J. FIRESTONE

Mr. M. WALLACE McCUTCHEON, Q.C.

Dr. C.L. STRACHAN

Dr. ARTHUR F. VAN WART

COMMISSION COUNSEL:

Mr. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

Dr. PIERRE JOBIN

DIRECTOR OF RESEARCH:

Prof. BERNARD BLISHEN

SECRETARY:

Mr. N. LAFRANCE



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COMMISSIONERS

Chief Justice HENRY M. LAMM --

DR. DAVID M. BARTON

DR. W. W. WARDEN, JR.

DR. C. W. STANLEY

DR. ARTHUR F. VAN WARE

MEMBERS

ASSOCIATES

DR. W. W. WARDEN, JR.

ASSOCIATES

DR. W. W. WARDEN, JR.

DR. W. W. WARDEN, JR.



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Quebec City, Province of
Quebec, Monday, April
9th, 1962.

--- On commencing at 10 a.m.

THE CHAIRMAN: Ladies and gentlemen,
we will now come to order and proceed with this hearing
in accordance with the notice which was duly published
in the local press. We are here in Quebec City to receive
briefs that any organization or person may wish to submit.
We do not appear to have a heavy agenda. We have had
advance notice of two submissions only. When these have
been heard anyone else present who may wish to be heard
will be given the opportunity to do so.

Wednesday, that is the day after
tomorrow, the Commission will sit in Montreal, where some
twenty-nine submissions are to be presented covering
practically all aspects of health services in Quebec by
provincial and national organizations.

I think it is only proper that I should
say that we are aware of the position which the Government
of the Province of Quebec has taken with regard to the
work of the Commission and to which I referred at the
Preliminary Meeting of the Commission in Ottawa on
September 27. We respect the views of the Government of
this Province as put forward by the Honourable Jean Lesage
in his letters to me of August 25 and September 1, 1961.
But, the position he takes is one which is not within the
jurisdiction of this Commission to decide. We have been
charged with making an inquiry into the existing facilities
and future need for health services for all the people of
Canada consistent with the constitutional division of
legislative powers. We have no intention to interfere
with or to ignore provincial rights. The larger questions



Quebec City, Province of
9th, 1962

--- On commencing at 10 a.m.

THE CHAIRMAN: Ladies and gentlemen,

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concerned with making an inquiry into the existing facilities and future need for health services for all the people of Canada consistent with the constitutional division of legislative powers. We have no intention to interfere with or to ignore provincial rights. The larger questions



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involved and referred to in Mr. Lesage's letters to me must, in the final analysis, be dealt with at the highest governmental levels.

It is pleasant to be in Quebec. I was born in this Province but went to Saskatchewan with my parents and brothers and sisters in 1910. I have been here in Quebec City several times in recent years and it is always a pleasure to come back. I hope that I may have the opportunity to return again soon.

As you know, Dr. Pierre Jobin of this City is our Medical Consultant. Dr. Jobin has been a great help to us as well as a most pleasant companion on our travels in the other provinces.

DR. JOBIN: Mr. Chairman, members of the Royal Commission on Health Services, the Health Services of Quebec are now ready to present their brief. I would like to introduce to you Mr. P.E. Charron, Chairman of the Quebec Health Services. Mr. Charron, will you be kind enough to submit to the Chairman and the members of the Commission of Health Services the brief of your association.

THE CHAIRMAN: This will be Exhibit 209.

--- EXHIBIT NO. 209: Submission of Health Services of Quebec.

SUBMISSION OF HEALTH SERVICES OF QUEBEC

(LES SERVICES DE SANTÉ DU QUÉBEC)

Appearances:

Mr. P.E. Charron
Jean Grenier

President
General Secretary

/contd...



Appearances (contd)

J.-E. Pelletier	Director
Claude Morin	Technical Advisor
J. de la Chevrotière	General Director
J.-Ed. Dorion	Administrator and Director of the Medical Advisory Committee
Lionel Sorel	General Vice-President of the Catholic Union of Farmers
Louis J. Marcotte	Assistant General Secretary of Council for Co-operation, Province of Quebec
M. Jean Marchand	President of the Federation of National Trade Unions

DR. JOBIN: Mr. Chairman, I would ask

Mr. Charron to tell us what are the Quebec Health Services
in a brief historical summary of the services.

MR. CHARRON: The Quebec Health Services
represents a mutual association of health services
founded in Quebec in 1944. This is a provincial company,
a mutual aid company of owners and users and beneficiaries
and each year they elect a Board of Directors which
administers for them. This is a non-profit organization
which has the name of extending to its beneficiaries
certain services and benefits against a premium and to
insure these services, benefits, medical and doctor
benefits, surgical benefits; part of the service is not
covered by the Health Services.

This organization represents 150,000
insured persons mostly in the families. Last year there
was given over four million dollars-worth of medical
services of all kinds extended to more than 1,000 groups.
That is, in brief, the medical health services.



Charron

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I must add that this organization also handles life insurance, insurance on salaries and other forms of protection.

THE CHAIRMAN: Do you insure groups or individuals?

MR. CHARRON: Most of our insured belong to groups, groups in industry.

DR. JOBIN: Mr. Charron will now present the submission of this brief. According to the instructions we have received you would like to present a summary of recommendations but after having read very carefully your brief I consider that Chapter II constitutes such a summary. If you will please read this and we will consider this as a summary of your submission.

MR. CHARRON: The health insurance plan proposed by the Quebec Health Services supposed the establishment of an administrative structure of the mutual and highly decentralized type. It would also be based on compulsory participation and would provide for universal medical coverage. It would be financed through premiums and would respect the principle of payment for medical service. We should also mention that it could only be established gradually and should definitely come under provincial jurisdiction.

These characteristics will appear more clearly in the second part of this brief where we shall describe the administration, operation and financing of the proposed plan. In the present chapter, we will merely summarize the suggestions made by the Quebec Health Services.

I must add that this organization also handles life insurance, insurance on salaries and other forms of protection.

THE CHAIRMAN: For your insurance groups or individuals?

MR. CHAPMAN: Most of our insured

belong to groups, groups in industry.

DR. JOHNSON: Mr. Chapman will now present

the submission of this brief. According to the instructions

we have received you would like to present a summary

of recommendations but also having read very carefully

your brief I consider that Chapter II constitutes a

a summary. If you will please read this and we will

consider this as a summary of your submission.

MR. THORNTON: The health insurance

plan proposed by the Quebec Health Services is based on the

establishment of an administrative structure of the

actual and highly decentralized type. It would also be

based on compulsory participation and would provide for

universal self-insurance. It would be financed through

premiums and would respect the principle of payment for

medical services. We should also mention that it could

only be established gradually and should definitely come

These characteristics will appear more

clearly in the second part of this brief where we shall

describe the administration, operation and financing of

the proposed plan. In the present chapter, we will

merely summarize the suggestions made by the Quebec Health

Services.



Charron

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Mutual character and decentralization

We state that the proposed plan would be of the mutual type because it would be included in the non-profit class of organization and would to a large extent be managed by the users themselves.

In order to guarantee control of the entire health insurance programme by the users themselves, the plan we propose would be of the pyramidal and decentralized type. The backbone of the structure, one might say, would be a "Provincial Health Insurance Company" made up of a certain number of regional companies having jurisdiction over their various branches. On the provincial and regional levels, there would be a board of directors elected by the insured or by their representatives which would also include persons appointed by the Provincial Minister of Health and the medical profession. The Provincial Company would be responsible for determining the scales of fees to be established in co-operation with the Provincial College of Physicians. The Company would also be responsible for collecting the premiums, should this mode of financing be chosen, and for paying benefits to the insured. These benefits would take the form of payment of professional fees to the physicians. As for the regional companies, they would attend to the establishment of branch offices (appointing staff, procuring equipment and premises, etc.) and to the physical administration of the companies and their branches. The regional companies would nevertheless remain under the control of the Provincial Company as far as use of the funds and determination of policies are concerned. The whole



Charron

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enterprise would be under the jurisdiction of a government health insurance administration.

Thus, there would be three levels of varying importance: the Administration, the Provincial Health Insurance Company and the Regional Companies and their branches.

Hence, this would be a joint plan in which certain elements drawn from the mutual concept would, so to say, be associated with the indirect participation of the public administration (through the Administration) in managing, financing and operating the health insurance programme.

Compulsory participation

The plan would be a joint one for yet another reason. A mutual undertaking proper is based on voluntary contribution -- no one is obliged to adhere to the plan and everyone is free to withdraw. Now, the programme we are proposing here does not entirely comply with this requirement since it takes into account, at least at the final stage of establishment, of the coercive factor of compulsory participation by the citizens. Indeed, if we want to ensure a better distribution of risks and if we want to provide really complete protection, in that all citizens will be insured, adherence to the protecting organization cannot be optional, except, when the programme is first established, perhaps, and then only for reasons of administrative facility. Needless to say free adherence by the citizens would be sufficient to incite most of them to join the health insurance programme, but nevertheless a minority, one which might quite well



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be in the order of twenty or twenty-five percent of the total population, may not agree to participate in the health insurance plan, either because they cannot or, mainly, because for some reason they do not wish to do so.

The possibility of their not participating and the fact, as we shall see further on, that the medical profession, as such, would not be obliged to co-operate in the proposed programme, may make it difficult to carry out and may cause it to lose, as far as the community as a whole is concerned, several advantages it may be granted at the start. Thus, two groups of citizens may be formed, one composed of those who, because of their state of health or their low income level, are more or less obliged to join the plan if they wish to be adequately protected against the risks of sickness, and the other made up of persons who, for the same reasons, operating inversely in this case, believe they can abstain from taking part in the programme. The latter would constitute the twenty or twenty-five percent of the population we have just mentioned and would be sufficiently numerous to cause a number of physicians, who would otherwise have joined the plan, to abstain in order to devote themselves entirely to this minority which, by that very fact, would become a privileged group in relation to the remainder of the population. Thus, voluntary participation in this connection might well penalize the poorer citizens or those who are frequently ill by placing them in a situation where they would be served by a proportionately smaller number of



Charron

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3 physicians because the remainder, and particularly
4 certain specialists, would prefer to tend the non-insured
5 population for whom they would reserve their services
6 exclusively. Assuming the public is left entirely free
7 to participate, the health insurance plan because of
8 such latitude might be unable to achieve one of the
9 aims that make its existence necessary, namely, adequate
10 medical services for all citizens.

11 There is, of course, no immediate
12 physical proof that the situation described here would
13 arise nor that it would be a serious one if it did.
14 However, in view of the fact that members of the medical
15 profession are human and that wealthy or relatively
16 well-to-do citizens would have a tendency to refrain
17 from joining a plan which would seem to them to be
18 intended mostly for the lower classes of the population,
19 it can be assumed that such a situation would occur.
20 It would, of course, be possible to see whether such a
21 danger exists or not once the health insurance programme
22 got under way, during the stages where participation is
23 not yet compulsory for the public in general.

24 With regard to the physicians they will,
25 in principle, remain free to participate or not. If on
26 the other hand, and as we would wish to see, participation
27 by potential patients is compulsory, it can be expected
28 that most members of the medical profession will co-operate
29 voluntarily in the programme. We will deal with this
30 question in greater detail in the chapter on operation of
the plan.



Charron

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Universal coverage of risks

Another characteristic of the proposed programme is universal coverage of risks. This characteristic presents three aspects. The first is that all medical care, that is, all care provided for any type of sickness entails benefits. Thus, in this respect, no exception is made as regards the nature of the disease, the length of time it lasts or the person affected. The second aspect is as follows: all expenses incurred by such care are covered, in other words the patient has no additional fee to pay either up to or above a certain amount. There is a third aspect, which, moreover, arises from the preceding paragraph, according to which the entire population is protected regardless of its level of income or its state of health.

If, however, medical care proper is included -- hence all professional services of the medical body specializing in one field or another -- this is not necessarily so in the case of drugs and surgical appliances for the reasons given in the chapter dealing with operation of the programme. Also excluded, for the time being, are dental services and some other specific services. Details on this subject are given in the same chapter.

Financing through premiums

The Quebec Health Services suggest that the health insurance programme be financed by premiums calculated on the basis of actuarial data revised each year in order to correspond to the actual cost of the programme and the administrative expenses.



Charron

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Despite certain drawbacks of an administrative nature, premiums offer certain substantial advantages among which, that of excluding the government as much as possible from the application of health insurance. The salaried workers who constitute the majority of the population could pay their premiums in full or partially through salary deductions -- the employer could contribute a given percentage of the premium, or not, or he could pay it in full. The self-employed could pay their premium once a year or at regular intervals. As for the destitute and the unemployed, the government would undertake to pay the entire premium on their behalf.

Payment for medical services

We are of the opinion that benefits, or more precisely, fees should be paid directly to the physician on receipt of an appropriate form which is done now in which the nature of the services rendered and the fees to be paid are indicated and the signature of the insured would appear on the form. Each time fees are paid, the client would receive a form showing the amount involved. Thus, the principle of fees for medical services would be respected and no limit would be fixed as regards the total revenue of physicians.

The P.M.I.C. would be charged with making such payments, but the regional branch would receive the physicians' bills. This organization would keep a complete record of such financial operations and, being close to the insured and the physician, it could easily make any necessary adjustments.

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strative nature, premiums offer certain substantial advantages among which, that of excluding the government as much as possible from the application of health insurance. The salaried workers who constitute the majority of the population could pay their premiums in full or partially through salary deductions -- the employer could contribute a given percentage of the premium, or not, or he could pay it in full. The self-employed could pay their premium once a year or at regular intervals. As for the destitute and the unemployed, the government would undertake to pay the entire premium on their behalf.

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making such payments, but the regional branch would receive the physicians' bills. This organization would keep a complete record of such financial operations and being charged to the insured and the physician, it could easily make any necessary adjustments.



Charron

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Medical fees and charges for surgical intervention, treatment, etc. would be in keeping with a pre-established schedule prepared by the P.M.I.C. and representatives of the medical profession appointed by the College of Physicians of each province. These rates would be maximum rates but not necessarily uniform. They would take into account local particularities (transport, cost of living, climate, population, etc.) between provinces or between areas within a province. They could also be modified upon agreement between the parties concerned if this should be found necessary and taking into account the financial possibilities of the funds available to the P.M.I.C. for health insurance purposes. Needless to say the schedule would be very detailed and any decision concerning it would have to be approved by the health insurance administration. Thus, it could not be modified unilaterally or to the disadvantage of one of the parties concerned. Finally, we would add that it would not be legal for a physician to claim a larger amount from the patient insured than the one foreseen in the schedule.

Progressive establishment

It cannot be conceived that a health insurance programme, in view of its size and the number of people involved in its administration and in the services rendered, could be set up suddenly, without acquiring some experience beforehand and without thoroughly studying both its social and economic repercussions.

This is why we see its definite



Charron

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establishment as the result of three quite distinct stages. The first stage would be that of formation when the administration and the P.M.I.C. would be set up and during which participation would be on a voluntary basis. In the second stage, that of consolidation, regional companies would be constituted and organized. Finally, when the third stage is reached, that of consolidation, the province would be covered by branches of the regional companies. From then on, compulsory participation would be required and other services (drugs, etc.) might be added to those already provided by the health insurance programme.

Provincial jurisdiction

Finally, if we state that the proposed programme should come under provincial jurisdiction, it is because the field of health, in view of the constitution of our country, belongs primarily and above all to such a jurisdiction. As we have already mentioned in the preceding chapter, we do not intend to prove this argument by interpreting the British North America Act or on the basis of sociological or historical considerations -- we take it for granted and we are firmly opposed to any joint programme in this matter.

However, it does not come within our purview to forbid the central government to take an interest in public health where matters coming explicitly within its competence are concerned. We merely wish to emphasize that, in our opinion, it cannot possibly work out a vast health insurance programme without taking into account the long established distribution of powers



Charron 7842

between the provinces and the central government and this, even if future action of the federal administration should go against certain precedents, in the field of health or other areas, where such distribution, although recognized in principle, has been neglected in fact. In other words, we maintain that in this connection, it is not possible to invoke, in order to justify any future action of a centralizing nature, precedents whose pertinency or necessity, despite the arguments used at the time they occurred, do not seem to have been established.

DR. JOBIN: Mr. Charron, would you wish to add something besides what you have just read from Chapter II of your submission and tell us what the structure is for the proposed health plan? You should feel quite free to answer yourself or ask your colleagues to do so.

MR. CHARRON: I would ask that Mr. Jacques de la Chevrotière speak on this.

MR. de la CHEVROTIÈRE: You will find on page 18 a chart which shows the proposed structure. Since we admit at the outset some intervention on the part of the Provincial Government, we might point out that the system, the entire system, would be under the jurisdiction of the provincial Minister of Health but at the lower level in this structure immediately after the provincial Minister of Health we have a Provincial Sickness Insurance Association which would be set up through appropriate legislation by the Government which would be the link between the governmental authorities

between the provinces and the central government and
this, even if future action of the federal administration
should go against certain precedents, in the field of
health or other areas, where such discussion, although
recognized in principle, has been neglected in fact.
In other words, we maintain that in this connection, it
is not possible to invoke, in order to justify any
future action of a centralizing nature, precedents whose
pertinency or necessity, despite the arguments used at
the time they occurred, do not seem to have been
established.

MR. JACQUES: Mr. Gagnon, would you

wish to add something besides what you have just said
from Chapter II of your submission and tell us what the
structure is for the proposed health plan? You should
feel quite free to answer yourself on this point
colleagues to do so.

MR. GAGNON: I would ask that Mr.

Jacques de la Fontaine speak on this.

on page 18 a chart which shows the proposed structure.
Since it starts at the outset some intervention on the
part of the provincial government, we might point out
that the system, the entire system, would be under the
jurisdiction of the provincial Minister of Health but at
the lower level in this structure I would like to see the
provincial Minister of Health to have a provincial
sickness insurance legislation which would be set up
through appropriate legislation by the government and it
would be the link between the provincial authorities



de la Chevrotière 7843

and the Quebec health insurance company, the Provincial Health Insurance Company.

This insurance control board is merely supervising, it would not have anything to do with the internal administration of the P.H.I.C. which might be compared to the public services board which exercises certain authority on the provincial or national government to ensure that public interest is safeguarded.

P.H.I.C. would be the same provincial body which would have jurisdiction over the system throughout the province. This company would be democratic in its set-up since the board of administration would be composed of the representatives, the elected representatives, elected or appointed by the regional companies, the regional companies being closer to the grass roots, as we might say, the public, and would be sufficiently numerous to cover the entire field of the province.

These regional associations would be capable of rendering all the services while the regional associations would have a role to play in the administration of the plan; perhaps it would be a purely administrative role, the regional associations would not lay down the policies but they would be responsible for applying at the regional, local level the policies to facilitate the operation of the plan.

Each regional association would have a certain number of branches, local branches, which would be even closer to the citizens.

If you look at page 22 there is a further graph which gives greater detail of the structure



de la Chevrotière 7844

of the Provincial Health Insurance Company. As you see, there would be a Board of Directors and all the administrative machinery necessary for the operation of the system.

We might emphasize here that is composed of the provincial association or the regional association, the various committees, the Medical Economy Committee, and this committee would be responsible for advising the Board of Directors of the P.H.I.C. on all matters relating to the medical field.

At the regional level there would be a medical committee composed of members of the medical associations whose judgments would be similar to those of the Medical Economy Committee but it would, in addition, be called upon to decide on various problems in the field of medicine or matters of litigation arising under the plan.

DR. JOBIN: Mr. Chairman, the members of the Health Services for the Province of Quebec are available now for any further questions you may wish to put to them.

THE CHAIRMAN: Well, Mr. Charron, do other members of your group have anything to add to what you have stated in addition to what has been said by yourself?

MR. MARCOTTE: Mr. Chairman, members of the Royal Commission on Health Services: the Council for Co-operation, Quebec, is a body responsible for the operation in the Province of Quebec which was established in 1939. This body takes into account the structure and



Marcotte

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all categories of co-operatives which carry on their activities in this province as well as certain interests or associations of provincial nature operating within the concept of co-operation and take an interest in the province in these co-operatives.

At the moment, in the Province of Quebec, the Co-operative Council groups consist of 1,200,000 people which draws its members from the labour income groups. This body operates democratically in the business of some 2,000,000 co-operatives in business and other activities.

The Council for Co-operation, Province of Quebec has taken cognizance of the proposals made by the P.H.I.C. in its submission.

Our Council wishes to submit certain considerations in this brief.

First, we wish to point out the important contribution made by the insurance companies - that the insurance companies have given and continue to give to the improvement of health of the people at large in the Province of Quebec.

Several of these co-operatives have been able, through their own efficient administration, to improve the medical services and extend these services to a large number of families in Quebec.

Secondly, the suggestions made by the Quebec Health Services indicate that the co-operative associations dealing with medical insurance are conscious that these are improvements for certain sectors of the population with their own means to provide sufficient medical



Marcotte

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protection and to ensure good health.

Our body is part of the service as rendered to the population of Quebec and if the governments feel it is necessary to supplement the services available to the population we believe the formula set forth in the brief submitted by the Quebec Health Services is a definite advantage.

Particularly this safeguards initiative and individual responsibility and collective responsibility of its citizens. Furthermore, it is up to us to offer the best and most efficient service to our population.

All the details of the proposed health services plan have not been given but this supports the main guide line. We maintain that public health comes within the provincial jurisdiction but we feel the Federal Government should freeze taxation to enable the provincial authorities to discharge their responsibilities in this field.

We are happy to support the brief submitted by the Quebec Health Services.

MR. CHARRON: With your permission, Mr. Chairman, Mr. Sorel wishes to say something.

MR. SOREL: Mr. Chairman and members of the Commission on Health Services: the Catholic Union of Farmers of the Province of Quebec wishes to say they are happy to support the submission made by the Quebec Health Services.

The Catholic Union of Farmers of the Province of Quebec represents about 40,000 farmers in all the areas of the province and has about 500 local



protection and to ensure good health.

Our body is part of the services as

rendered to the population at large and it is the province

ments feel it is necessary to a system and the services

available to the population we believe the services are

forth in the brief submitted by the Quebec Health

services is a definite advantage.

Particularly this said, and its initiative

and individual responsibility and collective responsibility

of its citizens. Furthermore, it is up to us to offer

the best and most efficient service to our population.

All the details of the proposed health

services plan have not been given but this supports the

main guide line. We maintain that public health comes

within the provincial jurisdiction but we feel the

central government should have a taxation to enable the

provincial authorities to discharge their responsibilities

in this field.

We are happy to support the brief

submitted by the Quebec Health Services.

Mr. CHAPMAN: With your permission,

Mr. Chairman, Mr. Chapin wishes to say something.

MR. CHAPIN: Mr. Chairman and members

of the Commission on Health Services, the Catholic

Union of Leaders of the Province of Quebec wishes to

say they are happy to support the submission made by the

Quebec Health Services.

The Catholic Union of Leaders of the

Province of Quebec represents about 10,000 persons in

all the areas of the province and has about 500,000



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unions throughout the province.

We believe that the character and the principle of our association permits us to speak on behalf of the farmers of Quebec. The great majority of the farmers in Quebec are small farmers and operate their own lands.

Quebec farms are family farms making a modest living. The problem arising because of illness becomes a very serious problem because of the modest financial resources available and the distances of medical assistance, the doctors.

Therefore, it should not be surprising that our body has given this some thought for several years and we have asked for the establishment of an insurance hospital plan.

Now that such a plan is in force in our province we are mindful to add to the need in this first stage those of our population who are less favoured having medical services which are both more complete and more adequate.

Our association has studied very carefully the submission made by the Quebec Health Services and we support the general principle not only because we are mindful of the need in the general field of health but especially because the submission seems to take into account certain fundamental principles which we are convinced should be maintained.

The lengthy experience of our association and our estimate of the concrete problems that will arise in the administration of health services leads us to



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believe very strongly the administrative structure of the mutual type of Quebec Health Services. We believe this type of administration is the best for individuals while, at the same time, making the population at large more mindful of what is involved by the implementation of such a costly medical and social health insurance plan.

We are also agreed in the principle of a fair, complete coverage received, a principle of payment for medical services which would be allocated only to certain types of medical service, would run the danger of leading to misunderstanding and raising criticisms which might negate the basis of any such plan.

Even if necessary to progress gradually, to go from stage to stage, it seems desirable but the general purpose to be achieved should be defined immediately and the population should be informed of the work to be done and the means that are available to achieve the impossible.

On the plan of hospital insurance our association has always asked for the respect of the provincial prerogatives; we have had the same approach in this plan of health insurance. The plan proposed by the Quebec Health Services, we have received provincial rights but this is an additional reason which has prompted us to support the brief submitted by the Quebec Health Services.

I am cognizant that the plan proposed meets our general concept of an insurance plan and we are happy to support the brief submitted by them and ask



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the Royal Commission to give this their full consideration.

THE CHAIRMAN: Thank you, Mr. Sorel.

MR. CHARRON: With your permission, I would now ask Mr. Jean Marchand, President of the Federation of National Trade Unions, to express his point of view.

MR. MARCHAND: Mr. Chairman, we thank you for having received us. I will read the submission. We wish to thank the Commission for having heard us this morning and wish to underline that we are here as an economist budget and have endeavoured to reach an understanding with our Quebec Health Services on the brief as submitted but there are a number of points on which we disagree.

We do not consider it necessary to rewrite a new brief and make new structures on the cost level. We think our friends from the Quebec Health Services are in a better position to make the submission but, nevertheless, we do suggest our brief should be given consideration, not as part and parcel of the submission of the Quebec Health Services but as a separate submission because we feel the trade union ---

THE CHAIRMAN: You wish this to be presented separately?

MR. MARCHAND: Of course, but we do support broadly the general principles in the submission of the Quebec Health Services. Nevertheless, our submission should be considered separately. I think we do refer in it to the position of the Quebec Health Services, we are not hostile to the approach or the



the Royal Commission to give this their full consideration

THE CHAIRMAN: Thank you, Mr. Goss.

MR. GOSSEL: With your permission, I

would now ask Mr. Jean Marchand, President of the

Federation of National Trade Unions, to express his

point of view.

MR. MARCHAND: Mr. Chairman, we thank

you for having received us. I will read the submission.

We wish to thank the Commission for having heard us

this morning and wish to underline that we are here as

understanding with our Quebec health services on the

brief as submitted but there are a number of points on

which we disagree.

We do not consider it necessary to

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separate submission because we feel the trade union --

THE CHAIRMAN: You wish this to be

presented separately?

MR. MARCHAND: Of course, but we do

support broadly the general principles in the submission

of the Quebec Health Services. Nevertheless, our

submission should be considered separately. I think it

is better to refer it to the position of the Quebec health

services, we are not hostile to the approach on the



Marchand

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approach of other associations but we are a distinct association and wish to thank the Health Services for permitting us to meet you together; we like to feel this is a demonstration of our good relationship.

As a trade union we have certain approaches and on certain fundamental principles we must disagree. We wish our brief to be studied separately and I would ask our Secretary-General to read our brief submission.

THE CHAIRMAN: Once we have disposed of the submission of the Quebec Health Services we can take your submission.

MR. MARCHAND: Very well.

THE CHAIRMAN: Are there any further submissions?

MR. CHARRON: No, thank you.

THE CHAIRMAN: Mr. Charron, may I say, on my own behalf and on behalf of the other members of the Commission, that your submission is a well-prepared one. You have proposed a plan, a specific plan. Now, not everyone would agree with that plan but you have certainly gone to great lengths to explain it.

Our Commissioners wish to ask questions in order to clarify some of your proposals and in this respect I have a few questions myself to ask in order to supplement the information I have gathered from the submission.

I will refer to the pages in your submission where I need information. Before that, however, the submission of the Quebec Catholic Union of



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Farmers will be Exhibit 209B.

--- EXHIBIT NO. 209B: Submission of the Catholic Union
of Farmers.

THE CHAIRMAN: On page 3:

"The problem to be solved. In our
opinion ill health in Canada is a
major problem and the entire popula-
tion must devote its efforts to
finding a solution."

Now, here you have a submission and I
ask you how you envisage this problem?

MR. CHARRON: Mr. Claude Morin, the
Technical Advisor, will reply to your question.

MR. MORIN: There are not very many
details, specific data, on the problem of the burden of
this problem for families and individuals. We know of
particular cases, everyone is aware of individual cases,
but we are not quite sure to what extent these problems
could be said to be general ones.

Nevertheless, with the official data
that are available, which are not very recent data, I
believe we have made an argument, namely, that the
question of illness is of considerable importance. I
am thinking of an inquiry that was made in 1951 throughout
Canada which dealt with medical services in Canada where
it was stated, inter alia, that 80% of the population
was ill at some time or another in the year.

It was also stated that additional



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data on the same problem - in addition to the additional data which came to 1951, we have other sources of information supplementing the first one which indicates an average income of the population is inadequate, generally speaking, to meet all the costs of medical expenses.

I am thinking, for instance, of the group of persons who have an annual average income of \$5,000 or \$6,000 a year who constitute the main group of the population.

Furthermore, we have more complete data of the experience in the Quebec Health Services which, in addition to the protection afforded to the population, we still have to take care of certain cases where there is not sufficient coverage under the plan.

We have had other associations that have had experience, the Association of Catholic Farmers, who have some difficulty in meeting all the requirements.

THE CHAIRMAN: On page 6, the second line ---

MR. CHARRON: What I had in mind is the road to health protection. If, in certain cases, the individual himself is responsible for his own bad health because of lack of care, unfortunately, the association has a certain responsibility for the fit state of health of its citizens. I am thinking of persons living under bad health conditions or inadequate education or sufficient training with regard to diets to be followed and proper food. In other words, there is a certain area where there is an overriding responsibility of things beyond the individual responsibility and, therefore, since



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society is responsible in part for this problem we think it is a responsibility to find a partial solution to this problem.

DR. JOBIN: Could Mr. Marchand clarify by telling us, the health of an individual, he is entitled to have his health protected ---?

MR. MORIN: I am thinking an individual has a right to enjoy a social standard and his health is part of his social standard.

DR. JOBIN: So the answer is in the affirmative?

MR. MORIN: Yes.

THE CHAIRMAN: In Chapter II on page 9 of the English text you recommend an administrative structure of the mutual and highly-decentralized type. Does this structure exclude the plan proposed by the physicians that the doctor should be part of the board of administration?

MR. de la CHEVROTIÈRE: We are proposing a centralized type of structure because we believe that the medical services should be available to citizens wherever they are located. I am not sure whether I understand your question.

THE CHAIRMAN: Are there any plans that are proposed by the College of Physicians of the Province of Quebec at this stage - there is no such plan proposed?

MR. de la CHEVROTIÈRE: To my knowledge, I cannot speak for them but I understand that the College of Physicians has already studied this problem and they would have suggestions to make to the Commission after



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they study this plan we have proposed.

THE CHAIRMAN: In the Province of Quebec there are no plans similar to suggestions in other provinces. We have the public health services in the Province of Quebec ---

MR. de la CHEVROTIÈRE: In the Province of Quebec we have public health services which is a medical plan where the physicians are represented, where the physicians are, so to speak, still operating independently. They act in the capacity of medical advisors but the crucial difference between the Quebec Health Services and most of the plans existing in the other provinces of Canada is that it is a mutual plan and not a plan controlled by the doctors. That is the main difference. Does this reply to your question, Mr. Chairman?

I would point out in this respect that with the structure we propose the physicians are represented ex officio in the area of administration, their powers are very limited and we do not believe in the public interest that the control at the national level should be in the hands of physicians or the users necessarily. We welcome the participation of the physicians in the board of administration but do not feel they should constitute a majority.

THE CHAIRMAN: Page 9, you speak of characteristics; why do you wish to have compulsory insurance - could it not be left free?

MR. de la CHEVROTIÈRE: We believe, Mr. Chairman, that in order to achieve the best possible



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solution it is necessary to have a compulsory participation. There are various reasons justifying this approach; first, from the point of view actuarial considerations, we think as broad a participation as possible is an advantage from the point of view of the citizens of the Province of Quebec.

We believe if insurance participation is free there will inevitably be a large important segment of the population that will not be able to participate because of lack of financial resources and perhaps there might be a further reason that could be advanced by the physicians; for instance, in the interest of the physicians themselves there is some interest in having all persons in it, not only those who can afford it.

It has been pointed out to me that if participation was open, or free, only those who could afford to initiate this would be covered and the less fortunate segment of the population might be deprived of medical services which is the purpose of our studies and which we are trying to solve.

We consider it a very important point that participation should be compulsory for everyone from the actuarial reasons I have pointed out. We, nevertheless, state in our submission that in practice it will perhaps not be possible to have compulsory participation from the start but we do believe it is necessary and desirable and that if it cannot be at the beginning it will inevitably have to be achieved if we wish to achieve our objective.

MR. DORION: Just another comment; I



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believe there is a danger that participation will not be compulsory because two groups might be constituted, those that deal with an insurance plan and those who do not. The physicians are not obliged to participate and there may be a greater proportion of physicians who would be available for the non-insured individual with the ultimate result that those who participate compulsorily will not have the same possibility of recourse to physicians.

THE CHAIRMAN: On page 12 you speak of the universal coverage of risks; do you propose to include in this plan mental disease?

MR. de la CHEVROTIÈRE: We have not specifically addressed ourselves to this aspect of illness. We are not quite sure whether this assistance is covered in other legislation or plans existing in other provinces but, in principle, I think there would be no objection to extending this coverage to mental illnesses. We feel this is possibly covered.

THE CHAIRMAN: The health services; do they presently cover mental diseases?

MR. de la CHEVROTIÈRE: Our association does not cover mental disease at the present time.

THE CHAIRMAN: On page 13, payment for medical services, and also on page 31. Do you envisage a special ---?

MR. de la CHEVROTIÈRE: No, we do not envisage the payment of a salary to physicians who deal with preventive medicine in the case of treatment. We feel, we believe, we envisage that the doctor or physician



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should be paid for his medical services, there is no objection in principle to that.

THE CHAIRMAN: I am sorry, it was page 39.

MR. de la CHEVROTIÈRE: As I was saying, we have no objection to having certain physicians receiving salaries, particularly in the field of research, public health and preventive medicine. In general, we would have no objection to having salaried physicians but as regards treatment where it is direct and personal contact between the patient and doctor, we feel there should be a payment for medical services.

DR. JOBIN: Regarding salaries, what do you think of the population living in far-away areas? If you feel payment should be for medical services then we should have individuals living in remote areas far away from medical centres, they should not be provided with adequate medical services or do you envisage that there should be a certain margin, a certain leeway, or a certain part of payment in the form of salary in the remote areas, in the Gaspé or similar areas far away from the medical centres and that certain physicians should be placed on a partial financial basis in remote areas?

MR. MORIN:: I may be able to answer part of this question. There is no objection to having the Government to encourage the physician to settle in remote areas of the province to give a certain remuneration which would be established on a certain level for payment for minor services. In other words, we have no objection



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in principle, to this approach to the problem.

MR. DORION: There is not much to add to Mr. Morin's comment; with the universal system we are advocating the physician being paid by everyone and even in the case of destitutes he is remunerated. The payment for medical services may be compensated in certain areas that the physician might live in and in other areas he might receive certain compensation from the Government and this would balance it.

THE CHAIRMAN: On page 13 you have provincial jurisdiction and you say:

"We are firmly opposed to any joint program in this matter."

MR. de la CHEVROTIÈRE: We believe that the Federal Government could maybe contribute to a health plan in a simple way which will enable the province to enjoy certain contributions.

THE CHAIRMAN: In case the Federal Government would leap only at the invitation of the province what problems would be created in the province ---

MR. de la CHEVROTIÈRE: Mr. Chairman, I think that by experience we know that it is quite normal that the one who pays may have a certain amount of control that it can implement regulations which might restrict the action of the provincially autonomous society.

THE CHAIRMAN: So you do not want anything from the Federal Government?

MR. de la CHEVROTIÈRE: We do require something from the Federal Government; the Federal Government might very well give to the provinces or help the



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provinces to get certain taxations - the Federal Government might not accept this kind of taxation and leave it to the provinces.

THE CHAIRMAN: On page 11 you speak of the administration sharing; what does that mean exactly? In what places would it be effective and with what kind of citizens?

MR. DORION: Mr. Chairman, what do we mean by the nature of the services; we might be giving consideration to certain cases, for instance, thinking of surgery which would be more complete in one place than another. There would be a certain providing for medical services if that medical service is not able to be had and, of course, salaries will be more important.

THE CHAIRMAN: On page 19 of the French text, would you say that this should be applied to all provinces or would each province be free to set up its own special structure?

MR. de la CHEVROTIÈRE: We think that the structure that we propose is a sound one and that, therefore, it could be applied to all the provinces. We also agree and recognize that it belongs to each province to establish these structures which will try to meet their needs.

THE CHAIRMAN: On page 26 of the French text, Chapter IV, and you have the insured risks; what about drugs?

MR. DORION: The drugs are very highly priced but eventually we hope that one day they may be added to the insured risks. So far we will not relate it



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to the plan we have and we thought, as far as, at least, in the beginning of this program, that this program for a certain time at least, we would cover first medical care and see later what could be added to that. Of course, we have no objection, ideally we have no objection, that the pharmacy can be added to the scheme.

THE CHAIRMAN: On page 30 at the top in the French text you speak of a plan which will cover all of Canada and you say that all Canadian citizens who have resided in the province at least six months could benefit from these programs but during these six months how will the sick people be covered?

MR. MORIN: Well, it may be three months because otherwise it would be impossible, it would mean visitors could be sent to have things done under the program - to benefit from the program. This is why we visualize a period.

THE CHAIRMAN: What about the fact of people moving from one province to another; do they still get this protection during the six months?

MR. MORIN: In this example, suppose that there is a health insurance program applied so that when they move from one province to another that they will be, for six months, maintained either from the province they come from or the province they go to.

THE CHAIRMAN: What time and how many months should a person have to reside in the Province of Quebec to recover it?

MR. de la CHEVROTIÈRE: I think about three months, if we speak of a Canadian citizen who moves



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from one province to another, of course, each will have to see that these Canadian citizens have a protection. Of course, it will have to be charged to the original province or perhaps it would be one in which he moves; there would have to be a certain continuity of coverage.

THE CHAIRMAN: On page 39, how do you manage to have this premium collected for the self-insured people?

MR. de la CHEVROTIÈRE: Well, I think it would be possible. I do not think it is more difficult to collect premiums from somebody than to collect for your telephone or electricity.

THE CHAIRMAN: Well, the electricity can be cut off.

MR. de la CHEVROTIÈRE: Of course, if the insured does not pay his premium the coverage is stopped automatically.

THE CHAIRMAN: But then do you give him the option?

MR. de la CHEVROTIÈRE: No, we have to make it ---

THE CHAIRMAN: But you said that ---

MR. de la CHEVROTIÈRE: We said in our brief that there must be an obligatory participation and, furthermore, that is what - there is a misunderstanding here - we talk of stages of establishment of a system and these problems would come progressively, therefore, it means at the start if we have a certain participation if a citizen does not pay for it, of course, automatically he will stop being covered. This is just the same as



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people who refuse to be covered but when it comes to the participation it will be ---

THE CHAIRMAN: What will you do if they do not pay? Will you try to get them to court? In other provinces that would be done.

MR. MORIN: Yes, the insurance company recognizes, as we propose here, presupposes the obligation to pay the premium so if such premium is not paid, of course, the organization will have such matters as necessary to protect the money.

THE CHAIRMAN: What about these destitute people? You said it is the Government who is paying these premiums. Now, how will you identify that group of citizens?

MR. MORIN: It is a most difficult problem and you are right to underline it. We have studied this carefully and we recognize that, of course, there will be some difficulty but we do not expect that these difficulties will be insurmountable. There will be a means of control not only of the state of continuation but we will try and - say, for instance, if a citizen has his premium paid by the Government it is not our intention to have control of all the property of a man. We say whether he is destitute or not but we shall fix a certain level under which the premium will be paid by the Government.

Now, this must be taken from each man; it does not mean a man who does not have enough money to buy the necessities to eat but people who have certain incomes but the income is insufficient so we think that



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under a certain level the Government will be able to pay for such people. We recognize this is a problem.

THE CHAIRMAN: Well, if one day we have your proposed plan, what would become of the problem that exists there? What will become of them if the plan you propose is implemented?

MR. de la CHEVROTIÈRE: Mr. Chairman, if the proposal we make is one day enacted, we do hope it will be and will solve all the problems that we do have with the private society which today deals with these things and health insurance will step readily into that; we think they will have to stop, that our insurance plan will take their place.

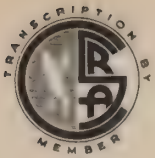
THE CHAIRMAN: What will happen with all these plans.

MR. de la CHEVROTIÈRE: I confess that we will have to make a difference. There are many kinds of companies which deal with health insurance and the majority of them are health and life agents, general life insurance in which the health insurance is only of secondary importance.

I think that these insurance companies will go on existing even if, for some time, they stop dealing with life insurance.

Now, this kind of mutual health plan like ours, there is no problem; they would come into the new companies but for other companies, they will have to have special recommendations exercised.

THE CHAIRMAN: You say that your plan must cover all the population, the whole of the population?



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MR. de la CHEVROTIÈRE: Yes.

THE CHAIRMAN: And you intend that the insured pay the premium only?

MR. de la CHEVROTIÈRE: Well, Mr. Chairman, that is the rule, that is the general principle but, of course, for certain reasons there may be cases, exceptions, which will be varied or exceptions to this rule. We can foresee the fact that a citizen will have to pay something which would be very small for services in special circumstances.

For instance, you may very well foresee, without endangering the system and without impairing its efficiency, that a certain man needs a physician during the night and he will be called upon to pay a certain minimum on top of the insurance to prevent an abuse, apart from the insurance. However, these sums would be very small indeed and will not impair at all the value of the system.

THE CHAIRMAN: Are you in favour of the charging of a certain remuneration?

MR. de la CHEVROTIÈRE: Well, yes, in certain cases it may be applied.

THE CHAIRMAN: What kind of charge?

MR. de la CHEVROTIÈRE: A limited one and, of course, when a man calls for a doctor during the night the physician cannot charge whatever he wants for that. This charge will have to be small and limited.

THE CHAIRMAN: So that the insured, as a rule, will not pay anything on top of the premium?

MR. de la CHEVROTIÈRE: Exactly.



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THE CHAIRMAN: In such a situation do you figure that all the physicians will have to participate in that plan?

MR. MORIN: Yes, but they would have this kind of preference: any physicians who do not belong to the plan could, of course, exercise their option and the ones who called them would have to pay them directly and have to pay what the physician asks. Of course, he will be allowed to receive from the customer the amount which the insurance company would have paid to the physician if he belonged to this plan.

In other words, there will be no extravagance that the doctor who does not belong to the plan cannot tax the citizen with the amount that he would normally have received.

MR. de la CHEVROTIÈRE: I would like to add, in fact we do talk or speak about the freedom of physicians but we suppose that the adherence would be enough to guarantee a good implementation of the plan. Of course, if you have the - we would have to inform ---

THE CHAIRMAN: How will you be able to determine the scale of the fees?

MR. de la CHEVROTIÈRE: Well, the scale of the fees will have to be determined in collaboration with the Medical College and, of course, the Provincial Insurance Company. Of course, the amount of fees must be equitable and the premium will have to be equitable also and will be within the scope of the citizen so the fees must be reasonable and the premium must be reasonable. This will be determined both by the Medical College and



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the Provincial Health Insurance Company and it will have to be approved by the administration, the central administration, which will determine if the fees are acceptable.

THE CHAIRMAN: Will the physician lose that privilege that he now enjoys?

MR. de la CHEVROTIÈRE: Yes, Mr. Chairman, I think this formula presupposes that the fees will be predetermined and the physicians will have to accept these fees for the service rendered.

THE CHAIRMAN: The physicians will not be very happy to accept direction as to what they should be paid.

MR. de la CHEVROTIÈRE: Well, since it is the College of Physicians of each province who, in co-operation with the Provincial Health Association, decides on the schedule, it seems that it can be taken for granted that the schedule of fees will be acceptable to the majority of physicians and that the scale of fees will be acceptable but for certain physicians there will always be the possibility of not participating in the scheme.

THE CHAIRMAN: What if the two parties are unable to agree?

MR. de la CHEVROTIÈRE: Mr. Chairman, that presupposes that the physicians at this time would be compelled to accept the schedule and it is quite conceivable that some of the physicians would be unhappy but we feel, as a whole, that the principle will be accepted by the College of Physicians.

THE CHAIRMAN: You see, therefore, that



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there is a possibility that differences of opinion might arise between the two parties concerned and in that case you say that the Government would take over control and would pay to the physicians the fee that has been established.

MR. de la CHEVROTIÈRE: It amounts to that except it would be power of administration - that is quite true, your submission is correct.

MR. MORIN: Mr. Chairman, in all this aspect of the matter it goes without saying that the fees will not necessarily be starvation fees, they will be set at a fair price level. The fees at this stage are fairly high so I believe that there will be some common ground which will be acceptable by both parties.

THE CHAIRMAN: You see, the total would be the sum total of the fees without the administration fees and expenses involved; am I correct?

MR. de la CHEVROTIÈRE: Yes, Mr. Chairman, the amount of the fees to be paid. Of course, for various reasons the total amount would include the fees and the administration expenses.

THE CHAIRMAN: So that the fee would be established by the Board of Administration?

MR. de la CHEVROTIÈRE: Yes, Mr. Chairman, the Board of Administration will pronounce the fees to be established and the amount of the premium and the Board of Administration could decide that the premium is too high and it should be reduced by a certain percentage and at that time it would imply certain adjustment of the schedule of fees.



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THE CHAIRMAN: Have you calculated the amount of the premium per individual or per family?

MR. de la CHEVROTIÈRE: Yes, in the brief we have submitted we gave this, an average family fee in the Province of Quebec, a premium of approximately \$11 a month.

THE CHAIRMAN: Per person?

MR. de la CHEVROTIÈRE: Per family. A premium of \$6 a month for an individual and I would draw your attention to the fact that this does not necessarily mean that represents the cost. The cost to the members would be slightly lower than \$6 per month but we say that it could reach \$6. There may be some adjustment. This is what we propose but we could require a slightly higher premium than what it may be for individuals, for bachelors, for instance, and charge a little less for the family.

THE CHAIRMAN: You have more than 5,000,000 people living in the Province of Quebec?

MR. de la CHEVROTIÈRE: Yes.

THE CHAIRMAN: How much money do you expect to need in one year to operate the plan?

MR. de la CHEVROTIÈRE: The minimum figure of \$125,000,000. Obviously this is in relation to the plan we have proposed and does not include the dental services.

THE CHAIRMAN: And excludes mental disease?

MR. de la CHEVROTIÈRE: Yes.

THE CHAIRMAN: Thank you for these clarifications.



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COMMISSIONER GIRARD: I have only one question for the time being. Economic considerations are outside my field but I wonder, Mr. Charron, whether you have envisaged the role of the voluntary associations within a scheme such as the one you are proposing?

MR. de la CHEVROTIÈRE: Miss Girard, what are you thinking of when you speak of voluntary associations?

COMMISSIONER GIRARD: I am thinking of the benevolent associations we have now which provide medical services such as the Polio Association and the Arthritis Association.

MR. de la CHEVROTIÈRE: No, we have not envisaged anything specific in this particular field. We do not think at first sight that the role of these functions, the role of these associations, will be changed and they would be able to continue their work.

COMMISSIONER GIRARD: You do not think they will be changed; even if all the population was insured for extra services there would still be people willing to give money to these benevolent associations?

MR. de la CHEVROTIÈRE: Oh well, I see, that is a horse of another colour which appears. It depends on certain associations whether you are the Canadian Cancer Society which deals with research, etc., and I do not think a medical insurance plan will solve this problem and I believe the population will continue to take an interest in matters of this kind, in this type of activity, and will continue to contribute money for research in cancer.



10-11-1964

Mr. ...

question for the time being. Economic ...
are outside my field but I wonder, Mr. ...
you have envisaged the role of the voluntary associations
within a scheme such as the one you are proposing?
MR. ...

What are you thinking of when you speak of voluntary
associations?

CHRISTOPHER ... I am thinking of
the benevolent associations we have now which provide
medical services such as the ... Association and the

envisaged anything specific in this connection? ...
We do not think at first sight that the role of these
functions, the role of these associations, will be
changed and they would be able to continue their work.
CHRISTOPHER ... do not think

they will be changed, even if all the population was
insured for a few shillings there would still be people
willing to give money to these benevolent associations?

MR. ...
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depends on certain conditions whether you are the
Canadian Cancer Society which deals with research, etc.,
and I do not think a medical insurance plan will solve
this problem and I believe the question will ...
to take an interest in matters of this kind, in this type
of activity, and will continue to contribute money for
research in cancer



de la Chevrotière 7870

COMMISSIONER GIRARD: You do not think their finances will be reduced? They would no longer receive the millions of dollars they do receive at the present time and some of these societies also provide medical services?

MR. de la CHEVROTIÈRE: Well, the situation might change to some extent. I must confess we have not discussed this.

COMMISSIONER GIRARD: Do you not think that the population would lose some of its voluntary action.

MR. de la CHEVROTIÈRE: Well, I think this aspect might be affected.

COMMISSIONER BALTZAN: I happen to be tri-lingual but none of them fits this occasion. While I have been very much interested in your presentation and I have tried to understand it, probably it would have been better if I could have gotten it in the original language.

I go to page 1 for a moment, paragraph A, and I am very much impressed with:

"In our opinion ill health in Canada is a major problem."

I am especially impressed with your use of the words "ill health" which covers a very wide category. Then you separate or divide things of a purely medical nature contributing towards ill health and you divide into a second portion the social solutions. Lumped together it makes the whole problem of medical health services an amazingly large one. Could we perhaps,



de la Commission

COMMISSIONER GILBERT: You do not think

that finances will be raised? They would not be raised. They would be raised by the millions of dollars they do receive at the present time and some of these activities also provide medical services.

Attention might change to some extent. I must confess we have not discussed this.

COMMISSIONER GILBERT: Do you not think

that the population would lose some of its voluntary action.

Mr. de la Commission: Well, I think

COMMISSIONER BARTON: I happen to be

tri-lingual but none of them like this occasion. While I have been very much interested in your presentation and I have tried to understand it, probably it would have been better if I could have gotten it in the original.

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use of the words "ill health" which covers a very wide

category. Then you separate on a wide range of a person

medical nature contributing towards ill health and you

divide into a second section the social situation.

Just a moment it makes the whole problem of a social

real service an extremely large one. Could we perhaps



Morin 7871

at the moment, separate some of these things?

First, in regard to the medical nature of the ill health problem, you stress, in the matter of ill health in your program, the prevention; you include that under your medical services.

MR. MORIN: We have made this distinction between a solution and a social solution to the problem of health merely to indicate that in the petition we do not speak of medical problems as such but what we are proposing is a solution of a social nature, a social solution. We do not cover the medical aspect of medical practice but we are looking only at the protection.

As for preventive medicine, we believe that with this program we are submitting, if it is accepted, we believe preventive medicine would be achieved and people who do require medical services could avail themselves of these services.

COMMISSIONER BALTZAN: In other words, according to your program it would be sort of a by-product. Does physical fitness come under your program or not?

MR. MORIN: As it is now the plan covers the public health measures that are taken care of and are implemented. We believe that in regard to physical fitness there may be programs implemented. What we are doing, what is presently prepared, is protection against the cost deriving from illness. It is limited in this particular aspect to the cost involved, the expenditure involved in seeking medical care.

We take all the health programs in existence and also those of physical fitness.



Morin 7872

COMMISSIONER BALTZAN: Thank you very much. You are then not strictly confined to the treatment of any illness so far as your program is concerned. I think I would leave this question very quickly with the knowledge from you that social aspect matters of a social nature to a large extent add to the burden of the total ill health problem and that aspect is not actually within your domain. Somebody must help towards that aspect and if that aspect is well looked after, let us assume theoretically well looked after, would you agree with me that the question of health services generally would be much less in total requirement?

MR. MORIN: Yes, quite possibly even if we take it for granted that certain measures are already in existence we do not take it for granted that those measures are perfect. We have limited ourselves exclusively to a program of protection for medical costs and everything going beyond this particular concern of ours may be imperfect; what is existing today may be imperfect or does not come within our scope as such.

COMMISSIONER BALTZAN: Thank you. If living conditions were better there would be less ill health?

MR. MORIN: That is so.

COMMISSIONER BALTZAN: I have learned here that your Association has existed since 1944 and my question is, in what way does your present brief enlarge or differ from the experience you have had in the last 15 or 16 years?

MR. de la CHEVROTIÈRE: Mr. Commissioner,



de la Chevrotière 7873

our brief does take into account the experience we have acquired in this field. To illustrate by an example, we will say that we have always, our Quebec Health Services attach considerable importance to medical services provided by the physician at the home or in his office. Our insurance plans contain this service and we have maintained that people who are not covered by medical services at home or for doctors' offices are more expensive than others.

Then there is medical-surgical services rendered at a hospital so we wish to ensure that it will possible to provide this benefit and, therefore, this new scheme arose to eliminate problems in the cost. That is something we have taken into account, the statistical data we have, in presenting our brief.

COMMISSIONER BALTZAN: One more thing: you have answered to the Chairman that you do not cover mental disease; do I understand by that you do not cover the cost of people entering institutions like the mental hospitals? Is that what you mean?

MR. de la CHEVROTIÈRE: That is quite correct, recognized institutions dealing with the treatment of mental diseases because there is a wide range, a complex range of mental disease, the really extreme cases of mental disease treated by specialized institutions such as St. Jean de Dieu in Montreal and St. Michel Archangel in Quebec; these patients are not covered by insurance.

Patients suffering from nervous diseases, these patients are covered by our insurance plan.

COMMISSIONER BALTZAN: But the great



de la Chevrotière 7874

proportion of cases who do not enter hospitals for transitional or mental diseases or maladjustments, the physician looks after him and does not enter them into custodial care; that patient is being looked after by his insurance company under your scheme?

MR. de la CHEVROTIÈRE: Yes.

COMMISSIONER BALTZAN: That is a great improvement. One final thing: I do not know whether I might address myself to the gentleman who represents the Farmers' Union ---

MR. de la CHEVROTIÈRE: He has gone.

COMMISSIONER BALTZAN: That is fine, I can leave my question hanging. Thank you very much.

THE CHAIRMAN: It is now 12 o'clock so we will adjourn until 2 o'clock.

--- Luncheon adjournment.



--- On resuming at 2 p.m.

SUBMISSION OF LA CONFÉDÉRATION DES
SYNDICATS NATIONAUX.

Appearances: M. Pepin, General Secretary
Martial Laforest) General
Henri Vachon) Vice-
Ted Payne) Presidents
Fernand Jolicoeur, Director
of Educational Services
Jacques Archambault, Technical
Advisor
M. Jean Marchand, President of
the Federation of National
Trade Unions

THE CHAIRMAN: Yes, Mr. Marchand?

MR. MARCHAND: Mr. Chairman and
Commissioners, our submission is not very long; as you
will see it is very short and I believe the best way of
disposing of it would be to read it and I will ask our
General Secretary to read the submission.

MR. PEPIN: La Confédération des Syndi-
cats Nationaux se réjouit de pouvoir présenter son opinion
aux membres de votre Commission sur cette importante
question des services de santé. Notre Confédération
groupe près de 110,000 travailleurs distribués dans à peu
près tous les secteurs industriels et commerciaux. Elle
a comme mission la défense et la promotion des intérêts
des travailleurs. A ce titre, elle se croit autorisée
d'exprimer l'opinion des travailleurs devant vous.

Au cours de ce bref mémoire, nous
tenterons de dégager en premier lieu l'importance du
problème et l'intérêt qu'il peut comporter pour un mouve-
ment comme le nôtre. Une deuxième partie traitera parti-
culièrement des principes de base d'un plan d'assurance
santé.



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I - Importance

L'établissement d'un régime de services de santé pour la population apparaît comme une nécessité de plus en plus urgente. Le coût des soins médicaux et chirurgicaux s'accroît constamment. Le budget des familles ouvrières est grevé pour des années par suite de la maladie d'un de ses membres. Les frais pharmaceutiques aussi coûtent de plus en plus cher. La conséquence est que les familles retardent la visite au médecin et attendent à la toute dernière minute. Alors que l'intervention médicale aurait pu être fructueuse au point de départ, son efficacité est souvent diminuée par un trop long retard.

Notre Confédération a mis sur pied, il y a quelques mois, un service d'aide aux budgets des familles ouvrières. Grâce à ce service, nous avons pu, à date, mettre le doigt sur divers problèmes, entre autres sur l'importance des coûts médicaux, chirurgicaux et pharmaceutiques dans le budget des familles. Il coûte cher pour prévenir la maladie, il coûte cher aussi pour la guérir. Nous pourrions citer de nombreux exemples devant vous de cette situation, mais elle est assez répandue pour que nous ne soyons pas obligés de nous y attarder.

Lorsque la famille ne peut payer le médecin assez vite, on remarque souventes fois que ce dernier remet son compte à une agence de collection. Il est normal que le médecin recherche le paiement de ses honoraires et nous ne faisons aucun grief sur ce point lorsque le montant des honoraires est raisonnable et



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justifié. Mais cette pratique qui s'étend constamment
a comme résultat de décourager davantage les travailleurs
de recourir au service des médecins.

Tous les citoyens du pays doivent
pouvoir se faire soigner lorsqu'ils sont malades et
même plus, ils doivent avoir le moyen de prévenir la
maladie en autant que possible. Tel n'est pourtant pas
le cas dans notre pays. Des citoyens devraient se faire
soigner et ne le peuvent pas financièrement. Lorsqu'ils
se font traiter, ils en portent le fardeau financier
durant des années.

Pour remédier à cette situation,
l'intervention de l'Etat nous apparait fondamentale.
Si la santé est un bien précieux pour l'individu, elle
est aussi bénéfique pour toute la société.

II - Principes de base

Avant d'étudier toute autre considéra-
tion, il nous faut aborder le problème de la compétence
du gouvernement canadien et des gouvernements provin-
ciaux dans l'établissement d'un régime d'assurance santé.
Il est bien établi que le domaine de la santé, en vertu
de la constitution canadienne, relève de la juridiction
des provinces. La situation idéale serait que chaque
province dispose de revenus nécessaires pour occuper ce
champ et dans cette hypothèse, il faudrait que toutes
les provinces appliquent un plan d'assurance santé pour
protéger tous les canadiens. Malheureusement, cette
situation idéale ne se recontre pas. Pour ce motif,
nous favorisons l'établissement d'un régime d'assurance
santé par un plan conjoint fédéral-provincial jusqu'à



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ce qu'une revision de la fiscalité au Canada soit faite. L'administration d'un tel plan doit, toutefois, être de la responsabilité des gouvernements provinciaux.

Dans ce mémoire, nous discutons en fonction de l'établissement d'un programme avec la formule d'un plan conjoint fédéral-provincial pour la raison indiquée ci-haut.

Nous n'avons pas l'intention d'examiner tous les aspects techniques de l'application d'un plan d'assurance santé. Nous ne croyons pas d'ailleurs qu'il s'agisse là de notre responsabilité. Nous devons toutefois constater qu'il y a un malaise social grave du fait que les citoyens sont aux prises constamment avec leurs problèmes de santé. Nous nous croyons justifiés d'indiquer les principes de base qui nous apparaissent fondamentaux pour protéger la santé des citoyens. Quant aux aspects techniques, d'autres, qui sont spécialistes en la matière, peuvent facilement s'en charger.

1 - Programme universel quant à l'application

Un régime d'assurance santé doit bénéficier à tous les citoyens canadiens. Il ne doit pas y avoir d'exception à cette règle. Un régime qui obligerait les citoyens à faire la preuve de leur indigence pour recevoir des bénéfices nous apparaît comme odieux et doit être rejeté. Nous réclamons donc un régime d'assurance santé universel, c'est-à-dire un régime qui s'applique également à tous les Canadiens sans égard à leur état de fortune.



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2 - Risques couverts

Un programme d'assurance santé doit protéger les citoyens contre tous les risques. Tous les soins médicaux devront être couverts quelle que soit la maladie et quelle qu'en soit sa durée. Il devra aussi être compris que le patient ne doit déboursier aucun supplément pour se faire traiter.

3 - Soins dentaires et produits pharmaceutiques

Le programme d'assurance doit s'attaquer aux problèmes des soins dentaires et des produits pharmaceutiques qui sont prescrits par le médecin. Il est peut-être difficile, au point de départ, d'inclure le paiement des soins dentaires et des produits pharmaceutiques. Mais la loi devrait prévoir que le paiement de tels soins sera assuré dès qu'il sera possible du point de vue financier et administratif.

4 - Choix du médecin et paiement à l'acte médical

Le patient devrait d'une façon générale pouvoir choisir son médecin. Dans l'exercice de la médecine, la compétence du médecin est essentielle, mais il faut aussi que le patient ait confiance en celui qui le traite pour en arriver à un meilleur résultat.

Une des objections de plusieurs médecins à l'instauration d'un régime d'assurance santé est qu'il s'agit d'une mesure d'étatisation de la médecine. Plusieurs médecins aussi soutiennent qu'en devenant des salariés, l'intérêt professionnel diminuera, ce qui sera néfaste pour les patients. Déjà, un



protéger les citoyens contre les risques. Tous
les soins médicaux doivent être couverts quelle que
soit la maladie et quelle qu'en soit la durée. Il
devra aussi être compris que le patient ne doit
débourser aucun supplément pour sa prise en charge.

Le programme d'assurance doit

s'attacher aux problèmes des soins dentaires et les
produits pharmaceutiques qui sont prescrites par le
médecin. Il est peut-être difficile, au point de
départ, d'inscrire le paiement des autres dépenses et
les produits pharmaceutiques, mais la loi prévoit
qu'il faut que le paiement de tels soins soit assuré dès
qu'il sera possible de point de vue financier et administratif.

4 - Projet de loi sur le régime d'assurance

Le patient devrait d'une façon

générale pouvoir choisir son médecin. Dans l'attente
de la médecine, la compétence du médecin est essentielle
mais il faut aussi que le patient ait confiance en
celui qui le traite pour en arriver à un meilleur
résultat.

Une des objections de l'assurance

médicale à l'instauration d'un régime d'assurance
c'est qu'il y a une mesure d'évaluation de
la médecine. Finances médicales aussi compliquées qu'on

se doit aussi noter que les patients, les



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certain nombre de médecins sont des salariés au service d'institutions privées ou de l'Etat. La fonctionnarisation des médecins n'est pas un idéal à atteindre ni une fin, mais ce n'est pas non plus un épouvantail comme on l'a présenté. Avec la coopération et la bonne volonté de tous, on peut en arriver à un régime d'assurance santé sans que le status des médecins soit profondément modifié.

Le plan devra déterminer les honoraires et assurer que le patient n'a rien à déboursier en surplus.

5 - Administration

Précédemment, il est indiqué que l'administration d'un tel régime doit être sous la responsabilité exclusive des provinces. Nous estimons aussi que l'administration doit être décentralisée. Sans discuter le détail de la proposition élaborée par les Services de Santé du Québec sans leur mémoire présenté à votre Commission, nous nous déclarons favorables à cette suggestion qui favorise la décentralisation administrative.

6 - Financement

Le mode de financement d'un tel régime ne doit pas être fait par le paiement de primes de la part des assurés. L'Etat doit payer directement le coût total à même ses revenus. De cette façon, les citoyens participeront au paiement suivant leur état de fortune comme pour les autres services sociaux.

Nous pouvons aussi ajouter que si le mode de financement adopté était celui des primes, de



certains nombres ne méritent pas d'être enlevés au service
 d'investissements livrés en de l'État. La formation
 tion des dépenses n'est pas un idéal à atteindre ni
 une fin, mais ce n'est pas non plus un objectif
 comme on l'a présenté. Avec la coopération et la forme
 volonté de tous, on peut en arriver à un régime
 d'assurance sans que le statut des dépenses soit

ne plus devra déterminer les dépenses
 et assurer que le patient ne soit à l'abri de
 l'abus.

2 - Administration

Évidemment, il est indiqué que
 l'administration d'un tel régime doit être sans la
 responsabilité exclusive des provinces. Nous estimons
 aussi que l'administration doit être centralisée.
 Sans discuter le détail de la proposition émise par
 les délégués de l'Ontario du Québec sans leur même pri-
 vation à votre commission, nous nous félicitons de l'adoption
 de cette proposition qui favorise la décentralisation

Le monde de l'économie mondiale
 ne peut pas être tenu par le pouvoir en place
 de la part des provinces. L'État doit pouvoir intervenir
 de façon à ce que les revenus. De cette façon, les
 systèmes gouvernementaux en place peuvent être
 et même comme pour les autres à l'avenir.
 Nous ne nous attendons pas à ce que
 mode de financement soit celui des États.



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sérieuses difficultés administratives se poseraient d'abord et que, de plus, il nous faudrait tenir compte de ceux qui ne sont pas en mesure de payer. Seraient-ils privés de soins pour ce motif? On répondra que pour cette catégorie, l'Etat paiera à leur place, mais alors nous revenons à cette fameuse preuve d'indigence que le citoyen sera tenu de faire pour bénéficier du plan, avec tout ce que peut comporter d'odieux et d'humiliant l'obligation de faire cette preuve.

Conclusion

L'établissement d'un régime d'assurance santé s'impose dans notre pays. D'ailleurs, un très grand nombre de pays reconnaissent dans les faits la responsabilité de l'Etat dans ce domaine, puisqu'ils ont établi de tels régimes. L'état de santé des Canadiens pourra ainsi s'améliorer à l'avantage de toute la société..

Nous ne sommes pas sans apprécier les difficultés techniques qui peuvent se présenter, mais elles ne sont pas insurmontables puisque d'autres y ont réussi.

Nous souhaitons que nos Gouvernements légifèrent dans ce sens en tenant compte de nos recommandations qui peuvent se résumer ainsi:

1. Plan conjoint fédéral-provincial jusqu'à la revision de la fiscalité au Canada.
2. L'administration doit en être laissée aux provinces.
3. Le plan doit être universel; tous



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la prise de notes pour ce motif. On répondra que
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alors nous revenons à cette même preuve d'indigence
que le citoyen sera tenu de faire pour bénéficier du
plan, avec tout ce que peut comporter d'incertitude
d'humiliant l'obligation de faire cette preuve.

L'établissement d'un régime
d'assurance sociale n'est pas dans notre pays. Différents
un très grand nombre de pays reconnaissent dans les
fautes la responsabilité de l'Etat dans ce domaine,
parce qu'ils ont établi de tels régimes. L'état de
santé des travailleurs pour ainsi s'améliorer à l'avance
l'âge de toute la société.

Nous ne sommes pas sans apercevoir
les difficultés techniques qui peuvent se présenter,
mais elles ne sont pas insurmontables puisque d'autres

nos souhaits que nos gouvernements
réalisés sans ce qui en tenant compte de nos
recommandations qui peuvent se réaliser ainsi :

1. L'impôt à la source de la fiscalité
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les citoyens sans exception doivent
être couverts et tous les soirs
payés et même éventuellement les
soins dentaires et les produits
pharmaceutiques.

4. Il doit être financé par voie
de taxation et non par le paiement
de primes.

THE CHAIRMAN: Thank you. Is there
anything further to be added?

MR. MARCHAND: Well, Mr. Chairman, in
reply to the question which was raised this morning, in
our mind the project should cover psychiatric treatment
and it should be a universal plan. Now, you perhaps will
find we have over-simplified this problem but all we wish
to indicate is the main basic principles underlying the
plan. We do not wish to go into the details because it
is outside our own field of competence.

We have not any insurance plan but we
do feel that the Health Services have made an effort in
this direction of a health plan and we support it
generally. We do, of course, object on four or five
main principles and we have put these principles in our
submission.

THE CHAIRMAN: You say that the responsi-
bility for the administration of the health plan should
lie with the Provincial Government; do you believe that
the Federal Government should give subsidies, grants, to
the provinces just as in the case of hospitalization?

MR. MARCHAND: You are speaking of a

les différents pays européens...
cette courbe est tout à fait
parce qu'il y a une différence
entre les données et les prévisions
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3 general plan and we have mentioned that in the text.
4 In connection with this situation we have no wish to
5 amend the British North America Act just for this plan.
6 We have our own ideas on this plan but we do think this
7 is an appropriate place to mention it. We have to take
8 the British North America Act as it is and we do not
9 wish to sit here as a Supreme Court of Canada. We have
10 to take the British North America Act as it exists today,
11 as it operates and it is very difficult to take it solely
12 on a provincial basis.

13 It is in this context that this issue
14 must be looked upon. We have presented our views but if
15 anything can be done in the present context we think the
16 Provincial Government should contribute. How should it
17 contribute? Well, in the same manner as it contributes
18 for hospitalization, half of the cost. We have no figures
19 in mind but surely we would have to contribute in part.

20 As to the amount, we would say that
21 each government should have sources of revenue depending
22 upon its fields of jurisdiction; in other words, if the
23 Provincial Government has certain jurisdiction or should
24 have the means of taxation. There has been some confusion
25 and we realize now there have been difficulties for the
26 people. We have our specific use.

27 THE CHAIRMAN: Well, the Province of
28 Quebec is not a poor province, looking at it from an
29 overall Canadian point of view. There are provinces
30 that are needy and poor and are not able to buy this, to
pay for a plan even if the British North America Act
could be changed. How would you handle this problem?



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4 MR. MARCHAND: Well, what we are
5 submitting, Mr. Chairman, makes it possible to have a
6 universal plan covering all of Canada with the Federal
7 Government registering part of its revenue in the form
8 of grants to the health insurance. We are not impressed
9 by the fact that some provinces would not be able to
10 pay for a national health plan, we would have that obligation to all provinces.

11 THE CHAIRMAN: Does that mean that the
12 rich provinces would help the poor provinces?

13 MR. MARCHAND: Yes, that is the implication. The only thing is, we are not very well convinced
14 that the Province of Quebec is a wealthy province.

15 THE CHAIRMAN: Well, if it is not a
16 wealthy province, you can tell us perhaps which are the
17 provinces which are wealthy?

18 MR. MARCHAND: Saskatchewan.

19 THE CHAIRMAN: Miss Girard?

20 COMMISSIONER GIRARD: Mr. Chairman, I
21 have not very many questions to ask on this brief except
22 that I wish to have Mr. Marchand clarify the services
23 they have to help families, working families. Is it a
24 research activity or ---?

25 MR. MARCHAND: Well, we have the confederation of services to help families to balance their
26 budgets. We have observed there were certain problems
27 with credit unions, etc., in relation to their budget
28 handling. We have been able to examine the problem of
29 medical care which arises in family budgets; the results
30 that we have from these surveys indicate that drugs,

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THE CHAIRMAN: Well, it is not a wealthy province, you can tell a province which are the provinces which are wealthy?

MR. MACKENZIE: Saskatchewan.

THE CHAIRMAN: Miss Giddens?

COMMISSIONER GERRARD: Mr. Chairman, I

MR. MACKENZIE: Well, we have the confidence

illustrate. We have observed there were certain problems with credit unions, etc., in relation to their budget handling. We have been able to examine the problem of medical care which arises in family budgets, the fact that we have from these surveys indicate that during



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3 medical care, surgical care, is a very important item in
4 the family budget. In other words, families that have
5 \$3,000 or \$5,000 revenue per year and who have a number
6 of children must devote a considerable part of their
7 family budget for medical care, drugs and surgical care.

8 COMMISSIONER GIRARD: But your object
9 is merely to advise the family, you do not help them
10 materially?

11 MR. MARCHAND: No, we do not give them
12 funds but try to guide them by saying "Look, you should
13 be able to prepare a budget" and we suggest that he can
14 go to such-and-such an association that will finance
loans. We give them advice in this respect.

15 COMMISSIONER GIRARD: On page 6 of your
16 brief - this question is for the benefit of Dr. Strachan,
17 my colleague, who is not in a position to put the question
to you in French. You say:

18 "Le programme d'assurance doit
19 s'attaquer aux problèmes des soins
20 dentaires et des produits pharma-
21 ceutiques qui sont prescrits par le
22 médecin."

23 I presume that you mean pharmaceuticals
24 in the dental care?

25 MR. MARCHAND: That is prescribed by
26 the doctor, of course.

27 COMMISSIONER GIRARD: In the same para-
graph you say:

28 "Mais la loi devrait prévoir que le
29 paiement de tels soins sera assuré
30



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dès qu'il sera possible du point
de vue financier et administratif."

By the word "administratif" here, are
you thinking of the personnel, administrative personnel,
that will be available or as regards to dental care there
is a serious lack of dentists in Canada; it is not a
question of having money but also a question of administra-
tion facilities and technical matters and personnel?

MR. MARCHAND: Yes, that is so.

COMMISSIONER GIRARD: Thank you.

COMMISSIONER FIRESTONE: If I under-
stand you and your associates correctly, you are proposing
a comprehensive medical care plan for the Province of
Quebec compulsory for everybody in the province?

MR. MARCHAND: In Canada.

COMMISSIONER FIRESTONE: You are propo-
sing it for Canada as a whole and applicable administra-
tively to the Province of Quebec, administrated in the
Province of Quebec by an authority set up in the province?

MR. MARCHAND: Yes.

COMMISSIONER FIRESTONE: This authority
that would be set up would include representatives from
the medical profession, the consumers of medical services
and the Government, the Provincial Government?

MR. MARCHAND: Yes, it would be a repre-
sentative body and we would hope the unions would be
represented also.

COMMISSIONER FIRESTONE: Can you suggest
any other representatives such as farm groups?

MR. MARCHAND: Well, the list - of course,



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I am not quite sure; you have the farmers, the workers, the doctors, professional associates such as nurses and I would be at a loss to indicate a complete exhaustive list but it should certainly be representative of the main social levels.

COMMISSIONER FIRESTONE: Would you want to retain the doctor-patient relationship under such a plan?

MR. MARCHAND: If it is possible but let us say in our concept it is not as rigid as perhaps it was set forth in the brief of the Quebec Health Services. I believe you can understand our general approach to this problem. In Canada one has the question of employment and a crusade is started to protect private initiative.

The objective is not to protect private initiative; of course, we have to protect individual freedom as much as possible but in the question of health there is a question of providing freedom for the physician but what we have to preserve is the health of the population which takes priority over the freedom of the doctor and the freedom of individuals to select their doctors, the freedom of selecting a physician.

This does imply a number of restrictions and I do not expect - the other specialists in the work, this freedom has also disrupted and there is no one trying to restore it. If we can safeguard it so much the better. Unfortunately, with a universal health plan certain freedom has to be restricted.

COMMISSIONER FIRESTONE: The price to be



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3 paid is on a fee-for-service basis?

4 MR. MARCHAND: As you observe from our
5 brief we have not taken any position, any specific posi-
6 tion on this point. Representing organization of persons
7 wage-earners, the population, generally speaking, wage-
8 earners, it is not up to us to say that doctors will
9 become wage-earners. We are not scandalized by this, we
10 think there are certain things necessary and we think it
11 is necessary - there are some doctors on salary who are
12 still devoted to their profession and there are others
13 who are not. We have no objection in principle if it is
14 a question of deciding on their proposal and it is a
15 reasonable one and if it will avoid abuses, we have no
16 objection in principle to the idea of payment for medical
fees but we do not think it is the only approach.

17 We are not convinced it should be a
18 premium feature; it could be tried out and we can see
19 how it works. We have no basic objection in principle
to that.

20 COMMISSIONER FIRESTONE: Would you
21 expect the physicians to join such a plan and operate
22 only under such a plan or would you visualize physicians
23 having an opportunity of earning outside income outside
24 the plan for services rendered?

25 MR. MARCHAND: Well, generally speaking,
26 I believe that the physicians should probably enjoy this
27 freedom but we fear the consequences very seriously. Even
28 if we give this freedom to the physician the physician
29 would be the first to limit this. There are only a few
30 doctors who are able to have large revenues in addition

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to the obligations they have under the plan. While we fear the consequences of this we do not say to eliminate this because we will have to have proof that public health will be looked after and safeguarded. We do not wish to adopt any rigid submission.

COMMISSIONER FIRESTONE: Would you visualize some doctors staying outside of the plan?

MR. MARCHAND: No, to the extent that it will be a universal one, we feel the doctors should all be in.

THE CHAIRMAN: All the doctors?

MR. MARCHAND: Yes; if we agree that this public necessity in medicine is essential for the public health of Canada why should certain individuals say that public health and public necessity is not any of their concern and should be able to have the freedom to work outside this concern which is the concern of all the population of Canada.

COMMISSIONER FIRESTONE: When you speak of the doctor you mean both the general practitioner and the specialist?

MR. MARCHAND: Yes, both.

COMMISSIONER FIRESTONE: Now, to turn to the other side of the plan, the question of how this plan should be paid for. As we understand your proposal it is that this plan should be compulsory as far as membership is concerned in the plan and the payment would be made by the Government out of general revenue; is that correct?

MR. MARCHAND: Yes.



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COMMISSIONER FIRESTONE: The Governemnt being defined as a Provincial Government and the Federal Government if there is a cost-sharing arrangement worked out; is that correct?

MR. MARCHAND: Yes, that is right.

COMMISSIONER FIRESTONE: Now, how will the Government pay for such a plan; through raising taxes?

MR. MARCHAND: If the Governments are not able to do this with their consolidated revenue or general revenue, they will find another means of taxation in some form.

COMMISSIONER FIRESTONE: Let us assume such a plan is introduced and the Federal Government contributes to the Province of Quebec as well as to the other provinces, say, 50% of the cost. Now, in order to raise this money, this contribution, it may have to raise income taxes; would your Federation support such an increase of income tax to pay for the share of the cost of providing a comprehensive health care program in Canada and the Province of Quebec?

MR. MARCHAND: Yes, certainly we would support this if there is no other means of increasing taxes or revenue. However, we would reserve our view as to the field of application of taxation. There are various forms of taxation in the country and we would not limit this form of taxation solely to income tax.

COMMISSIONER FIRESTONE: Let us say the Province of Quebec would want to pay for its share of the cost and they may feel they would want to raise



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income tax, perhaps corporation tax and perhaps sales tax; would your Federation support such an increase to pay for such a program?

MR. MARCHAND: Well, let us say that if the measures of social security - if you refer to the Province of Quebec, we believe that the companies who exploit the natural resources should have a greater share than they have had in the past.

COMMISSIONER FIRESTONE: Would you say as a matter of principle that you are in favour of a method of payment whereby people would pay according to their ability to pay for the cost of the national health program? Is that the principle that you want to apply?

MR. MARCHAND: That is quite correct. We believe those who are in a better position should contribute more to it than those who are less able to.

COMMISSIONER FIRESTONE: What would be your answer to those who would say they can look after their own medical care, those that do not wish to be covered?

MR. MARCHAND: Well, I think that this is the same argument that applies to all social measures, unemployment insurance or any other category of workers who can do without unemployment insurance because of their type of employment. When you take only the bad risk in any scheme then there would be no social security. Where people say they can take care of their own medical care they should, it seems to me, be called upon to contribute, to help those who cannot do it.

COMMISSIONER FIRESTONE: We have been



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4 they should have to pay more for medical care services
5 than it would cost them to look after it themselves.
6 What is the answer to this point of view?

9 7 MR. MARCHAND: Well, it is the same
8 thing, there is no social security plan that can help
9 because social security is the distribution through
10 government action in order to ensure social security of
11 the greatest number of people. Once you accept the
12 principle that you do not necessarily have to have it
13 as you have indicated, would mean handicapping the
14 principle of social security.

14 COMMISSIONER FIRESTONE: Therefore it
15 is really another suggestion for our own distribution
16 of income; is that correct?

17 MR. MARCHAND: Let us say that it is
18 not the direct aim or objective of the measure, we have
19 our own techniques where the distribution of revenue
20 approaches - the objective is to afford security to every-
21 one and the only way to afford security is for all groups
22 to contribute to it.

22 COMMISSIONER FIRESTONE: Would you feel
23 that the majority of people in the Province of Quebec,
24 under the present income levels, find it difficult to
25 cover the whole cost of medical care, dental care and
26 drug cost services?

26 MR. MARCHAND: Yes, categorically, it
27 is very difficult for the wage-earner in the working
28 class to pay for dental care, medical care and other
29 costs that would be covered with a health plan.
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It is very difficult for the wage-earner in the working class to pay for dental care, medical care and other costs that would be covered with a health plan.



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COMMISSIONER FIRESTONE: The majority of the people of the Province of Quebec do not earn an adequate income to pay for the full medical, dental and drug costs of an adequate and reasonable reserve which means that a minority which is in a better income group will have to contribute to the cost of the majority; is that correct?

MR. MARCHAND: Yes.

COMMISSIONER FIRESTONE: Are you in favour of that?

MR. MARCHAND: Yes.

COMMISSIONER FIRESTONE: That is true re distribution of income.

MR. MARCHAND: But it is true also in that it affects all sides of the wage-earner because there are people who would not draw any benefits from the scheme.

COMMISSIONER FIRESTONE: Would you feel that if there were such a scheme in operation in Canada, in which the Federal Government would contribute to a provincially-administrated program, and this provincial program would be paid out of the taxes and administered by a board which represents the major social structure of the Province of Quebec, including the medical profession and this plan would further involve the compulsory participation of the medical profession in the Province of Quebec, do you think that such a plan would be acceptable to the medical profession in the Province of Quebec?

MR. MARCHAND: I would be tempted to put this question to the College of Physicians but I



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believe at the present time most of the physicians of the Province of Quebec, we know a large number of them are willing to co-operate with a plan which would afford greater medical security to the population of Quebec. I am quite convinced it would be a matter of application. I would hesitate to pronounce whether all physicians would be willing to be salaried or wage-earners, I am not sure; but I am quite sure the principle of the plan would be greeted with favour.

COMMISSIONER FIRESTONE: Do you think if the Federal Government passed permissive legislation leaving it to each province for a program within the framework we have been discussing, the Province of Quebec, over a period of months or two or three years, could work out a program that was acceptable both to the general public, including unions across the province, as well as the medical profession?

MR. MARCHAND: I did not get that.

COMMISSIONER FIRESTONE: I will repeat the question a little differently. Assuming that the Federal Government proposed legislation to the Canadian Parliament and the Canadian Parliament enacts legislation whereby it would contribute 50% to the cost of a medical care program of each province provided the province complies with certain principles laid out in the terms of that proposal, do you think that the Province of Quebec, within a period of one or two years, could develop such a program on a co-operative basis in consultation with the medical profession and all other major groups along the principles which we have been discussing

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so far?

MR. MARCHAND: I believe that as regards the period of time required, I am not quite sure it would take one, two or three years. In the Province of Quebec at the present time so many problems are being studied and we have lost considerable time and are trying to catch up. I am not sure whether the Government would be ready to apply it in that period of time but I do feel, as far as the population and the Government to amend its plans, the one we have suggested seems to be the one most readily acceptable.

COMMISSIONER FIRESTONE: You would hope over a period of time a plan would be implemented once it is started?

MR. MARCHAND: I am convinced that pressure of public opinion is so strong as to expedite the action.

COMMISSIONER FIRESTONE: On page 6 you offer some comments about a dental program and a drug plan. You point out the difficulties of implementing such a program in the near future but you point out, if I understood you correctly, that this would be a desirable objective at some stage or other to go forward with, pre-paid dental plan and a prepaid drug plan; is that correct?

MR. MARCHAND: Yes, that is quite correct.

COMMISSIONER FIRESTONE: Now, can you visualize that this dental plan might be introduced in stages? For instance, you could cover initially children between the ages of 3 and 16 years and then, at another



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MR. MARCHAND: Yes, that is what I understand that this dental plan might be introduced in stages. For instance, you could cover partially children between the ages of 6 and 12 years and then, at another



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stage, other groups or categories of people in need of dental treatment. Can you visualize such a program in stages or are you anticipating that such a comprehensive program should be introduced in the dental field all at once?

MR. MARCHAND: No, we realize that a plan covering dental care entails many difficulties both from the point of view of dentists and the application of the plan itself. We feel that we should envisage the need to gather some experience and perhaps the better part of wisdom would be to work in stages in the provincial interest which is proposed in the Quebec Health Services which would advise the Government of the application of such a plan progressively.

Now, if, at a certain stage, everyone agreed it would be possible to do it all at once then I would think it would be better to do that.

COMMISSIONER FIRESTONE: You understand one of the problems mentioned to us is that we do not have an adequate number of dentists to introduce a comprehensive program in short order and it might take a number of years to work out adequate arrangements to provide a comprehensive dental care program. Would you feel that at least a beginning should be made towards a dental plan, a dental care program within the next five-year period?

MR. MARCHAND: Well, I am perhaps indulging, as you English say, in wishful thinking but I am not giving any specific indication on this score but there is something which appears quite urgent and that is preventive care, dental care, in order to cover the population as



stage, other groups or categories of people in need of dental treatment. Can you visualize such a program in stages or are you anticipating that such a comprehensive program should be introduced in the dental field all at once?

MR. MARSHALL: No, we realize that a plan covering dental care entails many difficulties both from the point of view of dentists and the application of the plan itself. We feel that we should emphasize the need to gather some experience and perhaps the better part of wisdom would be to work in stages in the provincial interest which is proposed in the Quebec Health Services which would advise the Government of the application of such a plan progressively.

Now, if, at a certain stage, everyone agreed it would be possible to do it all at once then I would think it would be better to do that.

COMMISSIONER FRIESTON: You understand one of the problems mentioned to us is that we do not have an adequate number of dentists to introduce a comprehensive program in short order and it might take a number of years to work out adequate arrangements to provide a comprehensive dental care program. Would you feel that at least a beginning should be made towards a dental plan a dental care program within the next five-year period?

MR. MARSHALL: Well, I am perhaps indulging, as you English say, in idealistic thinking but I am not



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early as possible. This stage could perhaps be taken care of sufficiently rapidly as soon as you have a sufficient number of dentists to handle it. There are quite a number of people who never have their teeth examined and perhaps we could take care of that aspect of the problem.

COMMISSIONER FIRESTONE: When you speak of a sufficient number of dentists becoming available, presumably you mean dental resources in the sense that some of the work may be done by dentists, some by dental auxiliaries, you have the whole professional field. You are in favour of a beginning to be made as soon as adequate resources are available to start a prepaid dental plan on a limited basis?

MR. MARCHAND: As soon as it is possible we feel it would be very desirable to start in this field.

COMMISSIONER FIRESTONE: Now, to turn to the other aspect of this program, you refer to the situation with respect to drugs; what are your views on the subject of the present level of the cost of drugs and what are your views on the subject of possibilities of introducing a prepaid drug plan in Canada?

MR. MARCHAND: Well, on the question of drugs, the position of our Confederation is that there are very serious abuses that have been observed. On the other hand, in the United States, a Commission investigated this field so we do not wish to accuse any particular group in particular before the Commission has looked into the matter but we feel something should be done to include into this, to determine the price of drugs and set them



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cient number of contacts to handle it. There are quite
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and perhaps we could take care of that aspect of the
problem.

COMMISSIONER FIRST: When you speak
of a sufficient number of contacts becoming available,
presumably you mean dental resources in the sense that
some of the work may be done by dentists, some by dental
assistants, you have the whole professional field. You
are in favour of a beginning to be made as soon as adequate
resources are available to start a prepaid dental plan on
a limited basis?

MR. HARRINGTON: As soon as it is possible
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into line, to determine the price of drugs and set a



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at a reasonable level.

We have asked the Federal Government, we have not received a reply and we hope to receive a reply. In any event, we do feel that the plan should cover drugs just as the other items are covered. Is there anything else I might add?

COMMISSIONER FIRESTONE: You are, therefore, in favour of a system which would assure the most efficient and economic distribution of drugs in Canada?

MR. MARCHAND: Yes.

COMMISSIONER FIRESTONE: Now, are you familiar that the Province of Alberta has introduced legislation recently to permit the distribution of drugs by generic name instead of brand name in the case of doctors' prescriptions, in the expectation that such an arrangement would bring down the cost of drugs as distributed and purchased by the patient?

Would your Union support similar legislation in the Province of Quebec?

MR. MARCHAND: Well, to my knowledge what I know I have read in the paper, I am not familiar with the law enough to be able to indicate that this is a direction we should wish to follow. We certainly favour an intervention in this field because there are scandalous and very serious abuses in the manufacturing and distribution of drugs.

Unfortunately, this blame is placed on the physicians and they are not responsible for this situation. It may be the firms that manufacture them.



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What is the best way of correcting these abuses? I think we should have an inquiry into this field to see what the problem is and we can tackle the solution. I am not in a position to indicate any solution.

COMMISSIONER FIRESTONE: Would you consider a possibility a national agency which would take care of drug distribution and drug costs in Canada and conduct studies to ascertain why these drugs are distributed at the prices they are distributed and make this information public so that both the Federal Parliament and the provincial legislatures as well as the public knows the facts and policies can be formulated to deal with the problem of the high cost of drugs, perhaps less efficient distribution of drugs.

MR. MARCHAND: We feel, and you have heard of this, no doubt, that the position of our Federation was to establish arbitration to the tribunals on prices of drugs, manufacturers of drugs, and they would have to prove before this tribunal the price of the drugs or increases are justified; to inform the public that the manufacturer has increased his price and they have to justify it as we have to do in the Union. In our Union if we want an increase we have to go to a board and justify our request.

If this applies to wages it should apply with even greater force to those manufacturing drugs. In this case the public would know the facts and the public opinion might exert certain pressures.

COMMISSIONER FIRESTONE: Would you have been in favour also of a plan for prepayment of drugs



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If this applies to wages it should apply with even greater force to those manufacturing drugs. In this case the public would know the facts and the public opinion might exert certain pressures. COMMISSIONER TROTT: Would you have been in favor also of a plan for preservation of drugs



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assuming that ways and means have been found to assure that drugs can be distributed at reasonable prices and in an efficient manner.

Assuming that this has been worked out in one way or another, would you feel that the time may be ripe to institute a plan of prepayment on drugs either in whole or in part?

MR. MARCHAND: Well, as for the drugs as prescribed by the doctor, there we feel it should be covered as soon as possible. As for the others, we feel that the measure that you have mentioned could be effective. What the public opinion objects to is that they have been given a raw deal in that certain medicines are prescribed and if you cannot afford this you can buy another type and this creates frustration.

A patient has not the means to pay for certain types of drugs then they have something less efficient for those who have not the money to buy and this is to avoid embarrassment of the patient. I think this situation should be corrected.

COMMISSIONER FIRESTONE: I am very much obliged to you for clarifying my question by saying your answer relates to drugs prescribed by the doctors which is really the area we are talking about.

THE CHAIRMAN: Before you leave that, do you wish to have the drugs distributed by an agency established by the province?

MR. MARCHAND: Well, for the drugs as prescribed by the doctor, I feel we should find the most economic and efficient means of distributing these drugs.

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in one way or another, would you feel that the time has

come to institute a plan of payment on drugs either

in whole or in part?

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than for those who have not the money to pay and this is

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attention should be directed.

MR. MARSHALL: I am very glad

to hear that you are clear about this.

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MR. MARSHALL: Before you leave, may

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There is no doubt if an agency such as the one suggested could purchase in bulk the drugs required, then the prices might be reduced considerably. We could see no objection to having the province as such or the agency as suggested could act as an intermediary in the distribution of drugs prescribed.

However, this does not appear to us to be the first stage to be covered. We see a large number of difficulties have to be overcome and this one in particular we feel will take care of a measure in order that results to the public health should be generalized so that there is no exploitation and that we have the best service possible at the minimum cost.

COMMISSIONER FIRESTONE: On this question of drug prepayment would you have in mind that patients purchasing these drugs may make a financial contribution or pay one dollar on each prescription or two dollars, in order to avoid misuse of the plan?

MR. MARCHAND: No, Dr. Firestone. In a democracy we have the principle that the population will abuse; if that is the approach we do not think it can possibly progress on a democratic basis. However, since there are very many possible fields of abuse not only on the part of the consumer, there are abuses in other areas, in other groups even - I am told certain abuses cannot be reduced and I think we should take care of these abuses.

COMMISSIONER FIRESTONE: Do you feel you can rely on the good judgment and discipline of the physicians to prescribe only drugs required and keep



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COMMISSIONER FLETCHER: Do you feel



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abuses to a minimum?

MR. MARCHAND: Yes, I would place my trust in the physicians on this score and if we withdraw our trust I do not think we can hope for anything.

COMMISSIONER FIRESTONE: You have presented us with some enlightened thoughts and we are very grateful to you.

THE CHAIRMAN: Gentlemen, Mr. de la Chevrotière stated that there might be an additional cost to be paid; you are against that? I take it you are definitely against that?

MR. MARCHAND: Yes, where this applies both to the patient and to the physician, in other words, it creates a situation where the physician will be tempted to look for his patients who pay better fees; we are likely to create an injustice. I believe that the plan itself should contemplate supplements of certain services but it should apply to all.

THE CHAIRMAN: It should not be paid by the physician?

MR. MARCHAND: No, I think the physician should be remunerated accordingly but if we did not object any discrimination or difference in remuneration, we feel it would create injustice and false and unfair competition.

THE CHAIRMAN: Thank you, Mr. Marchand and Mr. Pepin.

We will revert now to our discussion of this morning. The last brief will be Exhibit 210.

--- EXHIBIT NO. 210: Submission of La Confédération des Syndicats Nationaux.

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itself should constitute supplements of certain services

but it should apply to all.

THE CHAIRMAN: It should not be paid by

the physician.

MR. MARSHALL: No, I think the physician

it would create injustice and unfair competition.

THE CHAIRMAN: Thank you, Mr. Marshall.

MR. MARSHALL:

We will revert now to our discussion of

this morning. The next draft will be Exhibit 11.

--- Exhibit 11: Statement of Dr. Marshall in his

testimony before the



--- Continuation of Submission of Les services de Santé
du Québec

COMMISSIONER FIRESTONE: Mr. Charron,
I shall be asking the questions of you but please feel
free to call on any of your associates in dealing with
the questions.

As I understand it, your Association
is in favour of a comprehensive medical care plan compul-
sory for all citizens in the Province of Quebec; is that
correct?

MR. CHARRON: Yes, for Quebec and Canada.

COMMISSIONER FIRESTONE: And it would
be applicable to Canada as a whole?

MR. CHARRON: For each province.

COMMISSIONER FIRESTONE: Would it be
compulsory for physicians in the Province of Quebec?

MR. de la CHEVROTIÈRE: Mr. Firestone,
we believe that the system would be feasible through
voluntary participation. We feel that the majority of
physicians in the Province of Quebec would be willing to
co-operate in this system of voluntary basis approach.
With respect to the principle, we feel that if this
voluntary participation were inadequate we would have to
have recourse to compulsory participation.

COMMISSIONER FIRESTONE: In other words,
you would be saying to the physicians: "You either parti-
cipate voluntarily or we will make it compulsory"?

COMMISSIONER McCUTCHEON: What would
prevent them from leaving the country? What would prevent
the physician who did not want to participate from leaving



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the country or the province?

MR. de la CHEVROTIÈRE: Well, I do not believe that with this system we are proposing that the physicians - of course, it is a personal opinion - would be tempted to escape from our province. We are preaching and asking that doctors and physicians be treated reasonably and to be given reasonable fees and we do not think that even if in practice this implies the obligation in a certain number of cases of accepting a fee which they might otherwise have wished to receive a little higher, that these cases would be rare.

Even if this happens we do not think this would lead them to leave the country.

MR. MORIN: I would like to clarify a point; when we speak of voluntary participation of physicians we maintain the compulsory participation in the course of those particular cases when physicians, who are very few, might refuse en bloc to participate in the program.

Supposing there are 15 specialists in the Province of Quebec who are required for the continuation of the plan and if, en bloc, they refuse, then this particular group - there might be some penalty but it is a last recourse measure which would apply only in particular areas of specialization, it would not apply to the majority.

COMMISSIONER BALTZAN: I think you have had a double-barrelled question put to you. At the beginning you were asked whether your organization is in favour of a compulsory comprehensive type of service and



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3 in reading your brief I have noticed the compulsory
4 portion mentioned here and there but I do not recall any-
5 where in your brief that you used the word "comprehensive".
6 I do know if I remember correctly you used the word
7 "universal" but not "comprehensive" and there is a distinc-
8 tion between the two; "universal" means available to
9 everybody and "comprehensive" means everything available
10 to everybody.

11 MR. MORIN: We have, at page 10, given
12 a particular connotation to "universal" and the population
13 would be covered and the medical services would be
14 available and the total cost of the medical services
15 would be covered so that "comprehensive" is not translated
16 - it is the word "universal" that connotes that idea and
17 it means universal, comprehensive, in other words.

18 COMMISSIONER BALTZAN: Instead of it
19 being a double-barrelled question it is a hyphenated
20 answer.

21 COMMISSIONER FIRESTONE: Mr. Charron,
22 you suggested that this program might be introduced
23 initially on a voluntary basis and ultimately evolve into
24 a compulsory program. Your voluntary period is
25 apparently a period which you require to organize a
26 program in which you can reach a stage of your ultimate
27 objective which is universal coverage.

28 Would you be prepared to limit that
29 initial stage to a period of two or three years, otherwise
30 you may have an initial period of ten or twenty years?
Is that what you have in mind or have you in mind only a
limited initial period to get to this ultimate objective,



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say, two or three years; is that what you had in mind?

MR. de la CHEVROTIÈRE: We realize a short duration period in order to permit the more complete comprehensive implementation of the system. In fact, our suggestion was made to be as realistic as possible. We believe it is illusory to believe that in two or three months we can have the complete structure set forth.

In this submission we are thinking in terms of two or three years and further stages.

COMMISSIONER FIRESTONE: Now, you were kind enough in answer to Professor Baltzan's question to elaborate what you meant by "comprehensive". As I understand it, you refer to all medical care services that are considered appropriate in our present knowledge of medicine.

Now, the Chairman reminded me this morning, in answer to a question, the suggestion was made that mental health services might be deferred, might not be included in a plan in its initial phase; was I correct in that understanding?

MR. de la CHEVROTIÈRE: Yes, we have contemplated a certain number of medical services and ultimately all other types of services would be covered. This, again, was in order to present a realistic plan. We thought that a certain group at a certain stage and at other stages other groups would be included.

COMMISSIONER FIRESTONE: In other words, it is a comprehensive plan in all its phases but you are realistic enough to say that in the field of mental health you may not be able to do as much at the beginning but



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you may be able to do a great deal more at the second or third stage?

MR. de la CHEVROTIÈRE: That is quite correct. We ignore the cost of such a program which we know in the case of dental care there are not a sufficient number of dentists and as regards other stages, drugs, we know, and they represent a substantial sum of money which is as much as the rest of the medical program. We are thinking of a group of expenses that can be controlled, that can be identified and then we will go on later to other types.

COMMISSIONER FIRESTONE: Now, if a patient came to a physician and complained about an illness and the physician diagnosed this illness was largely due to mental disturbances, would such a diagnosis - that visit to the physician - be covered under the plan you visualize?

MR. de la CHEVROTIÈRE: Of course, this would be covered.

COMMISSIONER FIRESTONE: How far would you go in that first stage?

MR. de la CHEVROTIÈRE: That depends on the type of illness; if it was a case of imaginary illness which is encountered from time to time, it would be for the physician to explain to the patient that he is not really ill. If it is a more serious case then it would come to the category of mental illness.

I think we can add that the dividing line in the present circumstances might be the mere fact that as long as the patient, the mental patient or possible



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mental patient, is not treated effectively in an existing institution maintained for that particular purpose, until such time that the patient has not reached that stage he will be covered but once he has transferred to an institution then it would be another matter that we hope to cover in the future.

COMMISSIONER FIRESTONE: We have at the present time a system that takes care of people in mental institutions which is provincially-operated with a federal-provincial contribution; in other words, you have visualized your plan to work in co-operation with the existing plan to look after mentally disturbed people?

MR. de la CHEVROTIÈRE: Yes. At the present time, as I indicated a while ago, in practice our patients are not covered when they are treated in mental institutions under the responsibility of government and financed by Provincial and Federal Governments.

However, they are covered by their insurance until they reach the point of transfer to a mental institution. That is the line of division and at this stage it does presuppose a certain amount of co-operation between the two bodies. There is no objection to this co-operation.

COMMISSIONER McCUTCHEON: Do you mean other than that you are recommending that psychiatrists' fees be paid for patients who are not confined to mental institutions? Secondly, does your present scheme pay psychiatric fees for persons who visit psychiatrists once a week, let us say?

MR. de la CHEVROTIÈRE: Physicians are



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covered under our scheme and they would enter the proposed plan as regards patients received at the offices of psychiatrists for consultation. In the present circumstances, supposing they remain unchanged, the mental cases treated in a mental institution established for them and paid for by a joint federal-provincial arrangement, these patients, at the beginning, would not be covered by the plan.

In other words, the treatment received in the institution is not to be covered but all the other psychiatric services rendered outside of the mental institutions would be covered by the plan.

COMMISSIONER McCUTCHEON: And they are covered by your plan today?

MR. de la CHEVROTIÈRE: Yes.

COMMISSIONER FIRESTONE: If I may continue with this question of how such a program is paid for. As I understand it, your proposal suggests that payment of premiums by all those who can afford to pay premiums and payment by the State for those who cannot afford to pay premiums. Is that understanding correct?

MR. de la CHEVROTIÈRE: That is correct, sir.

COMMISSIONER FIRESTONE: How would you decide on the level of premiums? You are saying that you would establish those premiums on an actuarial basis; does that mean that you would divide the population into different risk groups and you would have different premiums for different groups or would you have one premium covering the population of the Province of Quebec



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as a whole?

MR. de la CHEVROTIÈRE: We would have a unique premium, a single premium established on the basis of actuarial data taken into account. Of course, the services insured the payment of this premium.

COMMISSIONER FIRESTONE: Would you then visualize that some people will be paying more than their actual cost would be and others will be paying less?

MR. de la CHEVROTIÈRE: Surely, this is the very principle of it.

COMMISSIONER FIRESTONE: Then, to continue, those people that cannot afford to pay the premium you suggest the State should pay for them?

MR. de la CHEVROTIÈRE: Yes.

COMMISSIONER FIRESTONE: You mention two groups: you mention the destitute and the unemployed; how would you define "destitute"?

MR. MORIN: As I said this morning in respect to these people with difficulties of an administrative nature - perhaps the best definition for "destitute" is without being necessarily arbitrary, it would simply declare that any person who had so many children and who have such-and-such a revenue will be considered, for the purposes of the insurance plan, destitute or unable to pay the premium.

These people whose revenue can be known without necessarily submitting them to a means test would benefit from this additional security benefit. In the case of the unemployed, so long as they are unemployed, they would not have to pay a premium under

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MR. de la CAISSE D'ALLOCATIONS FAMILIALES: We would have a

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What is the principle that some people will be paying more than their actual cost would be and others will be paying less?

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the plan. We know there is another administrative difficulty but we do not think it is insurmountable.

COMMISSIONER FIRESTONE: If we could examine this in a little more detail; you say there are several groups, they are what you call destitute, and you speak of another group of unemployed. Presumably the destitute can be defined as a group which are presently in receipt of public assistance or it could be defined as a group that do not pay income tax; some criteria that is objective and does not require a means test in every case or do you wish to have a means test in every case?

MR. de la CHEVROTIERE: No, we do not.

COMMISSIONER FIRESTONE: You are looking for a system that would give you a definition such as persons who have a low individual income that they are not required to pay income tax. In this case, presumably, they are in a low income tax bracket.

Have you any other suggestion of a system that will give you this category that will not involve having hundreds of thousands of people having to undergo a means test? Have you any idea or suggestion?

MR. MORIN: Yes, I was thinking the best approach would be to determine a certain level of revenue below which there would be no necessity to pay a premium. We could use the payment of social assistance as a criteria but perhaps it would be a dangerous one because all types of pensions that are granted are not for the same type of condition. It seems to be one of the great complications, the question of eligibility of certain

the plan. We know there is another administrative difficulty but we do not think it is insurmountable. COMMISSIONER FLETCHER: If we could examine this in a little more detail; you say there are several groups, they are what you call destitute, and you speak of another group of unemployed. Presumably the destitute can be defined as a group which are presently in receipt of public assistance or it could be defined as a group that do not pay income tax, some criteria that is objective and does not require a means test in every case or do you want to have a means test in every case?

MR. DE LA CHURCHILL: No, we do not.

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conditions in the administrative field.

COMMISSIONER FIRESTONE: You make a good case as to why the public assistance recipients are not a good manner of indicating this group which you call destitute. You suggested as an alternative that there should be a given level of income and that people below this income would be dealt with and people above that would not. Have you anything in mind?

MR. MORIN: We have not made any specific detailed studies but we are thinking that married people with one child who have an income not above \$3,000 a year, \$2,500 let us say, could be excluded from payment of this premium. Those who live alone, their level of revenue would be \$2,000, \$2,500. Those with ten children shall be another level of revenue. We realize there would be levels of income but we think this would be the best method, certainly before the criteria of public assistance.

COMMISSIONER FIRESTONE: I appreciate your looking for a level which perhaps would vary with the size of the family to take account of the minimum revenue required. Let us say you set up a system for a single person of \$2,000; a married couple, of \$2,500, two children, \$3,000 and so on to \$3,500 and \$4,000, depending on the number of children. How would you establish the income? How would you determine how much money these people are making before you can say "You do not have to pay a premium"?

MR. MORIN: Well, the annual income tax returns and, of course, we know this may be inaccurate.

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COMMISSIONER: Now make a

good case as to why the public assistance recipients are not a good manner of indicating this group which you said desirable. You suggested as an alternative that there should be a given level of income and that people below this income would be dealt with and people above that would not. Have you anything in mind?

MR. MARIN: We have not made any

specific detailed studies but we are thinking that perhaps people with one child who have an income not above \$3,000 a year, \$2,500 let us say, could be excluded from payment of this premium. Those who live alone, their level of income would be \$2,000. \$2,500. Those with ten children shall be another level of revenue. We realize there would be levels of income but we think this would be the best method, certainly be the levels of public

your looking for a level which persons would vary with the size of the family to take account of the minimum revenue required. Let us say you set up a system for a single person of \$2,000; a married couple, of \$2,500, two children, \$3,000 and so on to \$3,500 and \$4,000, depending on the number of children. How would you establish the income. How would you determine how much

MR. MARIN: Well, the annual income



Morin

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We still think the only possible means of determining the revenue in the case of the salaried people on a fixed income and certainly they cover the majority of people, I do not think there would be too much difficulty to control on the basis of income tax returns.

Now, we think the public health insurance plan have certain authority in this field and with co-operation I think it might be possible to determine the level of revenue of individuals to exclude persons with revenue below a certain level.

COMMISSIONER FIRESTONE: You would ask under this proposal of yours that the Department of National Revenue would communicate to the Provincial Insurance Corporation the income levels of all income tax payers in the Province of Quebec?

MR. MORIN: In the Province of Quebec in view of the provincial income tax which covers all the population and all the population of Quebec is required to file income tax.

COMMISSIONER FIRESTONE: The point you have been making, you would have the provincial income tax agency communicate the income levels to the Provincial Medical Commission?

MR. MORIN: No. Perhaps I was not quite clear on that. It would be for the person who wishes to claim exclusion from payment; the burden of proof would be on him to provide documentation that he is not required to pay the premium on the basis of certain established levels of revenue. The burden of proof would be on the person who claimed exemption from payment of the



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premium on the basis of the documentation stating his record.

COMMISSIONER FIRESTONE: I presume this person wanting to be exempted from the premium would have to fill out certain forms and provide certain evidence as to his income status and that would be checked by the Provincial Medical Commission; is that right?

MR. MORIN: Not exactly. There would be no need for control if we take the T.4 forms for his revenue and may be used in cases if we believe that there are two incomes. There would not be any more difficulty in ascertaining any more than the loan companies or the finance companies who require some evidence on income of individuals. There would be difficulties in certain marginal cases but we do not think it would be unduly difficulty.

COMMISSIONER FIRESTONE: In what way is this different from a means test?

MR. MORIN: Well, in that there is not in each case an examination and a compulsory obligation to expand on the level of income and the cost of food. We would not take all these controls into consideration; there would be one piece of documentation, perhaps the T.4 if he has a copy of it, his statement of income or statement of his employer. We did not go into details but we did not see that it would be as complicated or as burdensome or as repugnant as a means test.

COMMISSIONER FIRESTONE: In other words, you visualize a more limited examination, not as broad as a means test but an examination of income of the person



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concerned?

MR. MORIN: Yes, of the person who wishes to prove that he has not sufficient revenue to pay the premium.

COMMISSIONER FIRESTONE: You have been very helpful in defining what you mean by destitute and how you can translate such a thing into practice. You mention a second group, the unemployed and that group can be easily traced through the Unemployment Insurance records. I am wondering if there is not a third group; if I understood you correctly this morning you were saying that the majority of population in the Province of Quebec earn below \$5,000 or \$6,000.

MR. MORIN: Approximately 65% below \$5,000.

COMMISSIONER FIRESTONE: What was that percentage again?

MR. MORIN: 65%.

COMMISSIONER FIRESTONE: But I also understood you to say that it is this group also which has difficulty in paying all its medical bills, dental bills and drug bills.

MR. MORIN: I think that proof has not been made for particular cases but in view of the cost of health services it would average out at \$300 a year and on a salary of \$4,000 it represents a rather high amount.

In respect of the person who earns, say, \$1,000, they would want to facilitate this. We can set it at \$5,000 and their health protection, except where there is a major catastrophe, certainly would be ---



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COMMISSIONER FIRESTONE: You then say people in this income group find it difficult to pay for all their medical care services, dental services and drug services and that this group will be covered by this comprehensive plan of yours. Now, as I understand it, they will be obligated to pay premiums?

MR. MORIN: The premium, as we have said this morning, would be established for a family at approximately \$130 per year and divided by twelve that would be about \$12 or \$13 - \$11. It seems to us this would be a reasonable burden in view of the fact that there is complete absence, of course, of any major medical accident catastrophe. We feel, unfortunately, it would be a relatively higher burden if the revenue level is \$3,000 or \$5,000 but it is not any higher to support than the premium for life insurance or the cost of food.

COMMISSIONER FIRESTONE: You would not say you feel this \$11 per month would pay for the full health services covered or would it for some below?

MR. MORIN: Those we envisage in our brief are perhaps the most frequent and it does exclude drugs for which it would be possible to enact the specific legislation. We do not wish to go into this field because it is very difficult to establish the cost of these drugs and there are far greater difficulties of administration and multiplicity of the drug manufacturing companies.

COMMISSIONER FIRESTONE: You explained to us this morning that such a medical care program for the Province of Quebec may cost, in round figures, \$125,000,000 and about five million people, roughly about



Morin

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\$25 per annum per person; was I right in this understanding?

MR. MORIN: Yes.

COMMISSIONER FIRESTONE: If you have a family with five children the cost of the plan would be five plus two is seven, \$175, but this family would only be contributing \$130; where would the \$45 come from?

MR. MORIN: I believe that this is the whole advantage of the program since the program is unique in that a larger family would pay relatively less than those with fewer children. Irrespective of the number of children the premium would be fixed at \$11, those who have a large family would pay less and the \$45 missing would come from those who have fewer children.

In other words, rather than establishing the premium on a per capita basis and placing a big burden ---

COMMISSIONER FIRESTONE: Now, excluding those with large families or bachelors or spinsters, would it be paid out of taxes?

MR. MORIN: We visualize a plan with premiums and the others would be paid by people, by bachelors or smaller families. Each group would pay less or more, we have not gone into this.

COMMISSIONER FIRESTONE: How about people in this \$5,000-and-under group who can afford to pay some premium but do not earn enough to pay \$11 a day. We were listening to the presentation made this morning by the Confederation of Agriculture of the Province of Quebec and their problem is not only small incomes but



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125 per annum per person, was I right in this understanding?

MR. MORRIS: Yes.

COMMISSIONER FRISVOLD: It was a

a family with five children the cost of the plan would be five plus two is seven, \$175, but this family would only be contributing \$125; there would be the \$50 come from MR. MORRIS: I believe that this is the

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COMMISSIONER FRISVOLD: Now, excluding

those with large families or households on a interest, would it be paid out of taxes? MR. MORRIS: We visualize a plan with

premiums and the others would be paid by people, by households or smaller families. Each group would pay less or more, we have not gone into this.

COMMISSIONER FRISVOLD: Now about

people in this \$2,000-a-year group who can afford to pay some premium but do not want to pay that a day. He was listening to the presentation made this morning by the Confederation of Agriculture of the Province of Quebec and their position is not only small incomes but



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small cash incomes because they grow things on the farm and are fairly self-sufficient but when it comes to cash payment it is sometimes very hard for them to find all this cash money to pay for the premium. Now, would you pay the difference of what the families in this group can afford to pay and what the program requires them to pay?

MR. MORIN: It is not impossible to envisage that the program in taking into account the actuarial data, even if we have fixed it at \$11 as an average cost, our program is not impossible, as is the case today, to consider a special category. Farmers, for instance, would be exempted from special taxes on fuel, gasoline or other charges so that since the premium may be \$11 for city dwellers it may be less for those in the country but we have not gone into a calculation on that.

COMMISSIONER FIRESTONE: We are really talking of three categories who may have some assistance from the Government; one, those who are destitute; two, the unemployed and three, those that have an income but whose income level is below that which would enable them to pay the full premium.

A group that we have described in technical language as the medically indigent people who cannot afford to pay or can only afford part of it; they have a reasonable income but it is not enough. From what you say there are three categories for which some means must be found to pay their premium.

MR. MORIN: I would estimate that this



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would represent about 15% of the population in Quebec. In other words, there are 8% or 9% drawing their income from the farms and about 5% or 6% belonging to the category of persons who receive social assistance or those who have not sufficient income to pay the premium. 10% or 12% or 15% in the special category but for the others we feel \$11 would be acceptable.

COMMISSIONER FIRESTONE: How about the unemployed?

MR. MORIN: The unemployed, a duplication of categorizing which should be avoided. We should not calculate them twice, the total figure may be 15% and the unemployed, we hope, will be for a temporary duration.

COMMISSIONER FIRESTONE: We all are hopeful that unemployment will be temporary but in case it is not we still have to provide for a plan that will take care of people that are unemployed, whether it is temporary or more than temporary.

The question I would like to ask is: do you know the number of persons that are now unemployed in the Province of Quebec?

MR. MORIN: At the present time I believe - I am not sure - I believe 160,000.

COMMISSIONER FIRESTONE: 160,000?

MR. MORIN: Yes.

COMMISSIONER FIRESTONE: If there are 160,000 persons unemployed, they have families, they have children; it may involve about 600,000 persons.

MR. MORIN: But the number of unemployed



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in the month of March is big and perhaps we can take the average for the year and assume that the economy of the country will improve although it is not quite certain yet, I should say.

You would add something further, we consider the premium at the starting point but it is not necessarily a premium based on strictly actuarial data. We have not been able to go into details on calculation; this would take far more exhaustive studies than ours.

COMMISSIONER FIRESTONE: Well now, you feel confident there are only about 15% of the population involved because we have to think of the number of unemployed involved and the problem remains in the winter months that people are not able to pay the premiums and if you add the 600,000 persons unemployed to the number of farmers - how many farmers and families are there?

MR. MORIN: The rural population is 7.9 of the labour force.

COMMISSIONER FIRESTONE: What number is involved?

MR. MORIN: I am not quite sure but I think it is more than 100,000.

COMMISSIONER FIRESTONE: That is for people occupied on the farms?

MR. MORIN: Yes.

COMMISSIONER FIRESTONE: How much when you add their families?

MR. CHARRON: The Farmers' Catholic Union presently includes 43,000 members and those members are family heads, owners of farms; a proportion of 99%.



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COMMISSIONER FIRESTONE: We do not want to get into too much statistics but it might be useful if some further consideration could be given as to the numbers that would be involved. I am suggesting to you that if you include all the unemployed whenever they occur, together with the farm groups together with those in the public assistance group and eliminate duplication that you refer to, then this might involve more than 750,000 or 15%. Very little would be gained at this stage to engage in an exercise on statistics but if you would consider the matter a little further what your considered opinion would be of the groups affected would be helpful to us so we can see if your proposal is practical. Would that be acceptable to you?

MR. MORIN: Yes.

COMMISSIONER FIRESTONE: I would like to come to the second aspect of the payment and that is how will the premium be paid for for those who cannot pay the premium themselves, the three groups which we have defined? How would they be paid for?

MR. MORIN: These premiums could be paid by the Government and they would be exempt and each year the State, on the basis of per capita per family, would have to pay the amount that would have to be paid.

COMMISSIONER FIRESTONE: When you speak of the State do you visualize that the Provincial Government would pay, or the Federal Government would contribute to such payments?

MR. MORIN: We are speaking of the Provincial Government when I say "State" here. Of course,



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all the premium would be paid by the Provincial Government in this case.

COMMISSIONER FIRESTONE: I appreciate your suggestion that the Provincial Government should pay for the premium of those who cannot pay for themselves?

MR. MORIN: Yes.

COMMISSIONER FIRESTONE: Now, what are your objections to the Federal Government contributing to paying some of the cost of those that cannot pay for the health care themselves?

MR. MORIN: I think you would speak of the Provincial Government simply because we have recognized that our plan would be exclusively at the provincial level without collaboration of the Federal Government, financial contribution. Why? Because it is tied in with our starting point, namely, that health is a matter within the jurisdiction of the province.

COMMISSIONER FIRESTONE: Well, how do you feel about the present federal-provincial hospital insurance plan as in operation in the Province of Quebec?

MR. MORIN: We have not, naturally, looked into this problem. We have limited ourselves to the problem of health insurance and perhaps my colleagues might be willing to make a few comments. We believe that certain difficulties may have arisen because of the particular conditions of application required by the Federal Government which did not fit in with the particular situation, constitutional situation, of the provinces.

I am not quite familiar with that but it is a general comment I make.



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COMMISSIONER FIRESTONE: Are you agreed with the principle of the federal contribution to the Province of Quebec to finance the hospital insurance program?

MR. MORIN: No, we are not agreed that the Federal Government should participate financially or even in the establishment of a health program. We believe, nevertheless, that if the Province of Quebec - the provinces in general, it means on raising revenue this problem would not arise.

COMMISSIONER FIRESTONE: This has been very helpful. Would you visualize that if a plan were established such as you propose that this would be acceptable to the medical profession of the provinces?

MR. MORIN: I think it would be acceptable and the plan we are proposing we think would be acceptable to the physicians because it coincides with all the principles that physicians subscribe to. But, as has been explained, it is not for the physicians we have developed this plan because we feel the realistic approach to the problem is the one we have.

COMMISSIONER FIRESTONE: If the Provincial Government proceeded to implement such a plan as you have proposed and it would have to make a contribution to pay the premium for people in the three groups which we have defined and this would involve increased taxes to pay for it, would your Association support such an increase in taxes?

MR. MORIN: I would say that since the amount which the Provincial Government would have to



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3
4 contribute would not be too great as compared with the
5 overall charges, we wonder whether it would be necessary
6 to raise taxes and if it is necessary we have not
7 discussed it very much. We do not think we would have
8 any objection in principle to raising income tax, for
9 instance, or corporation tax or other sources of taxation
since the amount would be a limited one.

10 On the other hand, public health
11 protection is a major interest.

12 COMMISSIONER FIRESTONE: Thank you, you
13 have been very helpful.

14 THE CHAIRMAN: Thank you, Mr. Charron,
15 for the brief you have submitted and for the replies and
clarifications.

16 MR. CHARRON: Mr. Chairman and members
17 of the Commission, with your permission I have to communi-
18 cate a letter which has been received by the Professional
19 Association of Industrialization who have taken stock of
20 our brief and have asked us to present to you a letter.

21 --- Reads letter.

22
23 THE CHAIRMAN: Could we have a copy of
24 this letter?

25 MR. CHARRON: Yes, Mr. Chairman. It is
26 our duty now to extend our best thanks for the willingness
27 you have demonstrated in hearing us and putting all these
28 questions to us which indicates the interest you have
29 shown in this brief we have submitted. We are very pleased
30 to submit this brief.



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THE CHAIRMAN: Are there any further speakers at this stage? If not, this will end our hearings in Quebec City and we shall start our hearings at Montreal at 10 o'clock on Wednesday morning next.

--- Adjournment.

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ROYAL COMMISSION ON HEALTH SERVICES

ENGLISH VERSION

HEARINGS

HELD AT

MONTREAL

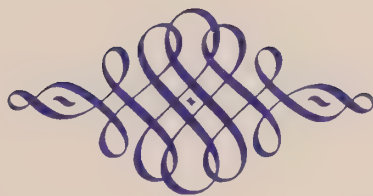
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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing held
at Montreal, Wednesday, April
11th, 1962

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

Miss ALICE GIRARD, R.N.

Dr. DAVID M. BALTZAN

Prof. O.J. FIRESTONE

Mr. M. WALLACE McCUTCHEON, Q.C. -- Acting Chairman

Dr. C.L. STRACHAN

Dr. ARTHUR F. VAN WART

COMMISSION COUNSEL:

Mr. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

Dr. PIERRE JOBIN

DIRECTOR OF RESEARCH:

Prof. BERNARD BLISHEN

SECRETARY:

Mr. N. LAFRANCE



Montreal, Province of
Quebec, Wednesday,
11th April, 1962.

--- On commencing at 10 a.m.

THE ACTING CHAIRMAN: Gentlemen, we are here this morning to open the hearings which have been advertised to be held in the City of Montreal, of the Royal Commission on Health Services. This is not the first time we have been in le Province de Quebec, we had sittings earlier this week in the capital city of Quebec.

I am sorry that the Chairman was called away unexpectedly and will not be with us today but we hope he will be back tomorrow. Had he been here he would have opened these proceedings in two languages but unfortunately my French is of such a nature that it can only be understood by non French-speaking individuals so I am not going to attempt to impose upon you this morning.

The first submission that we have this morning is that of L'Association des Médecins de Langue Française du Canada and I will ask Dr. Jobin to introduce the representatives.

SUBMISSION OF L'ASSOCIATION DES MÉDECINS DE

LANGUE FRANÇAISE DU CANADA.

(Exhibit No. 211)

Appearances: Armand Rioux
Raymond Caron
E. Rolland Blais
Emile Blain
Audie Leduc
Pierre Smith
Edouard Desjardins

DR. JOBIN: Mr. Chairman, I wish to introduce the Director-General of the Association of French-speaking Physicians of Canada, Dr. Blais.



1 Dr. Blais, would you be so kind as to
2 read the summary of the recommendations of your memoran-
3 dum or statement.

4 DR. BLAIS: Mr. Chairman, our Association
5 represents more than 5,000 Canadian doctors who are
6 French-speaking and exercise their profession in nearly
7 all the provinces of Canada. This brief is limited to
8 general aspects of the problems under consideration. We
9 base the considerations which we are submitting upon the
10 the practical experience that our members have acquired in
11 their daily contact with the health services of the country.

12 Our brief contains two parts; the first
13 part notes certain real or imaginary gaps in the organiza-
14 tion of care to the sick and the second part deals with
15 a draft form in respect to circumstances, financial
16 availabilities and requirements involved.

17 In the first part it is stated that
18 medicine is too expensive, that the number of physicians
19 is insufficient and that some physicians do not have the
20 desired competence and that because of all these health
21 services become inaccessible to part of the population.

22 Today the individual is stating that
23 he is entitled to good health and entitled also to have
24 that means protected. This assumes, of course, that he
25 himself will co-operate in this keeping of good health
26 by submitting to the rules of preventive medicine and
27 not leaving it entirely up to others to see to it.

28 The extent of Canada and the unequal
29 density of its population makes distribution of medical
30 services difficult. Any change in health services must



1 take account of the legal aspect of the matter and recog-
2 nize the exclusive right of the provinces to make laws
3 in this connection.

4 In the second part our brief states
5 that each Canadian province should have the necessary
6 financial means to organize at home in the provinces
7 any new plan of health services in accordance with the
8 new formula. If the new formula is adopted, health
9 services should be available to all within reach of all
10 and must include medical care at home, at the office of
11 the doctor and in the hospital.

12 Any financial contribution of the bene-
13 ficiaries of the plan should serve exclusively - should
14 be spent exclusively towards the course of the enterprise
15 and health services should remain within the jurisdiction
16 of the medical office or bureau which will assure its
17 quality.

18 Remuneration of participating doctors
19 shall be proper and shall correspond to the rates
20 established by the College of Physicians and Surgeons
21 of the province. Any patient shall be entitled to choose
22 his doctor and, conversely, the doctor should be
23 entitled to accept or refuse a patient except, of course,
24 in the case of an emergency.

25 The doctor may become established
26 within the province where he wishes to be in order to
27 exercise his profession.

28 In conclusion, the Association of
29 French-speaking Physicians of Canada recognizes the
30 establishment of a plan which would be in conformity

1 take account of the legal aspect of the matter and not
2 raise the exclusive right of the province to make laws
3 in this connection.

4 In the second part our brief states
5 that each Canadian province should have the necessary
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24 The doctor may become established
25 within the province where he wishes to be in order to
26 exercise his profession.
27 In conclusion, the Association, I
28 President of the Association of Canadian Physicians and
29 establishment of a plan which would be in conformity



1 with the following conditions:

2 All the citizens of the province would
3 be entitled to medical care and the province would pay
4 for the contribution of indigent persons in full; would
5 pay in part the contribution of persons with small salary
6 and would leave to all others the responsibility of
7 paying for their own in toto.

8 Those who do not wish to use the plan
9 may have free recourse to the private services of doctors
10 in accordance with the usual scale of payment.

11 Physicians who wish to may work exclu-
12 sively or partially with private practice. The provin-
13 cial body in charge of carrying out this program should
14 be independent and outside any political influence.

15 Financing of the project will be guaran-
16 teed by the total contributions received by a propor-
17 tionate contribution of the provincial government and
18 possibly by federal participation so long as agreements
19 are unchanged.

20 In the application of this plan the
21 principle must be respected for participating doctors
22 of remuneration for medical acts. It must be expected
23 that the carrying out of such a project will call for
24 a great deal of expenditure. It will also meet with
25 great difficulty in its implementation but since the
26 Canadian population really desires this it must expect
27 the drawbacks and recognize it is wisest to accept the
28 status.

29 To sum up, the Association of French-
30 speaking Physicians of Canada is in favour of any new



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 be entitled to medical care and the province would pay
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It seems to me, the Association of the
 Association of Physicians of Canada is in favour of any new



1 measure which is liable to improve health services in
2 Canada and in order to be effective, this new system
3 must be oriented towards the dual objective of making
4 these services available to all and to supplying services
5 of high quality.

6 The Association has no negative point
7 of view to submit in this matter; on the contrary, it
8 states that it is ready to participate in any construc-
9 tive program capable of improving the present situation.

10 To that end the Association feels a plan
11 of medical assistance would benefit those who need it but
12 it is of the view that such a program should be accom-
13 panied by all possible protections in order to give the
14 result that is sought.

15 The common need requires that such an
16 enterprise should be proceeded with by stages and never
17 losing sight of the objectives which we have had at the
18 start; that is, to make it accessible to all of the
19 excellences of services supplied.

20 The recommendation of such a plan
21 should be a matter for the provincial jurisdiction, and
22 in such a case we should avoid making medicine a State
23 matter, because so to do would be going counter to the
24 objective we are seeking to attain, for the quality of
25 medical care is based on the one hand on the confidence
26 of the patient in his physician, and on the other hand
27 on the knowledge and the understanding of that person.

28 Any new system which would destroy that
29 personal relationship would, in the final analysis, lead
30 to a paradoxical situation, in which the patient would



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 to a pathological situation, in which the patient



1 become no more than a card, an impersonal and numbered
2 card, and the physician an anonymous distributor without
3 any other initiative or stimulation, and it may be feared,
4 we believe, that State medicine may finally lead to such
5 an undesirable result.

6 If we really wish to have a change for
7 the better, it would be proper to start off on the right
8 foot, and in such a serious matter we should avoid
9 having to find out later that we have taken the wrong
10 road.

11 The Association of French-speaking
12 Doctors of Canada realizes the new requirements which
13 exist within the country. It wishes to co-operate fully
14 in the transition which is necessary, but it believes
15 that there is, as elsewhere, logic, sincerity, and fore-
16 sight, which should retain their full rights.

17 DR. JOBIN: Mr. Chairman, this brief
18 is deposited in the archives as No. 211.

19 The members of the Association are now
20 at your disposal to answer any questions from yourself
21 or the other Commissioners.

22 THE ACTING CHAIRMAN: Thank you very
23 much, Dr. Blais. Before any of the members of the
24 Commission ask questions, are there any of your colleagues
25 who would like to add anything to what you have said?

26 DR. BLAIS: No.

27 COMMISSIONER VAN WART: Dr. Blais, I
28 wish to thank you for your thoughtful brief, and I have
29 one or two questions I would like to ask you.

30 Under your conclusions, Section D, I am



1 not just sure what you have in mind, but have you in
2 mind a Commission outside of the Department of Health
3 to run your plan?

4 DR. BLAIS: We believe that the organiza-
5 tion of this provincial plan should be given over to a
6 Commission. Does that answer your question, sir?

7 COMMISSIONER VAN WART: Yes. There is
8 one thing not mentioned in your brief; that is the
9 question of priorities. You recognize that there is a
10 shortage of personnel, and shortages in the other fields,
11 such as mental health, and so on. Do you feel that a
12 plan should be given priority over the establishment of
13 corrections in these other fields, such as mental health
14 and soon? Do you feel that a plan should be given priority
15 over the establishment of corrections in these other
16 fields?

17 DR. BLAIS: I didn't quite understand
18 the question, sir. Would you be so kind as to repeat
19 it?

20 COMMISSIONER VAN WART: You realize
21 that there are shortages in personnel to operate the
22 health systems we have at the present time; that is,
23 medical personnel, nursing personnel, para-medical
24 personnel. Also shortages in the program of mental
25 health, and so on. Do you think that a development
26 along the line of these priorities, these things that
27 I have mentioned, should be given priority over the
28 development of an overall health plan?

29 DR. BLAIS: Yes sir, I think that in
30 the organization of a plan of this kind there are elements
31 which are more important, and more urgent than others.

32 In view of the fact that the number of
33 doctors is almost insufficient at this stage, and



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COMMISSIONER VAN WART: Yes, sir.

that there are shortages in personnel to operate the
 health systems we have at the present time; that is,
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 personnel. Also shortages in the program of mental
 health, and so on. Do you think that a development
 along the line of these priorities, these things that
 I have mentioned, should be given priority over the

establishment of an overall health plan?

MR. FLAHERTY: Yes, sir, I think that in

the organization of a plan of this kind there are elements
 which are more important, and more urgent, than others.
 In view of the fact that the number of
 doctors is almost insufficient at the present time, and



1 according to all likelihood will become definitely
2 inadequate in the future, I think the first thing that
3 we should have in mind is to supply this adequate number
4 of physicians, and I think that particular attention
5 should be given on the side of teaching of medicine in
6 order to increase the number of physicians. Does that
7 answer your question, sir?

8 COMMISSIONER VAN WART: Yes. Have you
9 any suggestions how we should go about it to increase
10 the number of people taking up medicine? Have you
11 given that any thought?

12 DR. BLAIS: I think that as we are all
13 human, one of the good ways of attracting the young
14 people to the medical career, would be to make it inter-
15 esting, as it is stated in the text of our brief. If
16 young people are not attracted that way, they will go
17 to other professions and occupations, the preparation
18 of which is less long, and occupations which may require
19 less sacrifice.

20 They should be attracted towards the
21 study of medicine in order to swell the ranks of profes-
22 sional medical persons in the country, by making the
23 study interesting and attractive, and by showing them
24 that in the future, if they pass their medical examina-
25 tions and become doctors, they will not be exactly civil
26 servants, and they will be able to earn their living
27 like other people.

28 I think that in the same sort of idea,
29 as a sort of corollary, the schools of medicine should
30 necessarily be broadened if we want the number of



1 physicians increased, but, of course, the schools of
2 medicine should have the financial means to increase
3 their size and perfect their courses. This also pre-
4 supposes, as mentioned further on in our brief, that
5 those who will decide to go and practise their profession
6 in isolated places may be a little compensated for that.
7 That will be a way of facilitating the distribution of
8 medical services in Canada.

9 COMMISSIONER BALTZAN: Dr. Blais and
10 gentlemen, it is my very great regret that I have not
11 had a chance to read in detail your very excellent
12 brief, which is both good philosophically, realistically
13 and practically, so my questions come up quite spon-
14 taneously as I have listened to you.

15 You mentioned in the very beginning
16 that you have your brief in two parts, and I refer to
17 Part I, where you say it is something real or imaginary
18 in the way of gaps.

19 Do you mean that if any action is
20 taken you would like to see those gaps taken care of
21 first?

22 DR. BLAIS: As I mentioned in the
23 summary sir, was that we believe that there are inade-
24 quacies. There are things that can be perfected.
25 Always there are things that can be perfected, including the
26 exercise of medicine.

27 I also think that certain complaints
28 have been made against modern medicine, medicine in our
29 days, which are not justified. That is what I meant
30 when I said real or imaginary inadequacies. I think



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serves, as mentioned further on in our brief, that

those who will desire to go and practice their profession

in isolated places may be a little compensated for that.

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medical services in Canada.

conclusion, it is my very great regret that I have not

had a chance to read in detail your very excellent

brief, which is both good philosophically, realistically

and practically, so my criticisms come up quite un-

generously as I have listened to you.

Let me mention in the very beginning

that you have been cited in two papers, and I regret to

hear that there was any in it something real or imaginary

in the way of facts.

Do you mean that if any action is

taken you would like to see these papers taken care of

Dr. BRUNNEN: As I mentioned in the

papers, we have no belief that there are

patients. There are things that can be learned

Always there are things that can be learned, including

the question of practice.

I also think that certain conditions

have been made against national medicine, medicine in our

days, which are not justified, that is what I mean

when I said that of imaginary handicaps, I think



1 we agree that the exercise of medicine in Canada of the
2 medical care given to the patients could always be
3 better than it is now. Furthermore, a reproach is made
4 to medicine in our country with respect to some things
5 which we believe are at least, that these reproaches
6 are at least exaggerated. It would seem that there is
7 a desire to require doctors to supply things which
8 cannot be required of other people, and there I think
9 that the complaint is a little imaginary.

10 A little further on in the actual text
11 of the brief we mention that any formula couldn't
12 change the condition of man, that is his personality.
13 A new formula, a new system, which could, of course,
14 improve the actual gaps which exist, but does not change
15 the means, that will not change the nature of man.

16 There will always remain some that are
17 good and some not so good, and it is these complaints
18 that I take as imaginary gaps.

19 COMMISSIONER BALTZAN: To what extent
20 does your Association attempt to bring forth these
21 things that they state about the medical and allied
22 professions? Do you come before the public and make
23 these things known to the patients and the public, or
24 impending patients? Do you have any program of educating
25 the people to understand these things?

26 DR. BLAIS: We believe, sir, that this
27 education of the public should be, before anything else,
28 an individual matter, in the sense that the practitioner
29 may, within his practice among his clients, try to
30 eliminate those misunderstandings which may exist today,

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DR. HALL: We believe, sir, that this
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may, within his practice among his clients, try to
eliminate those misunderstandings which may exist today,



1 but we have between the medical class and the public on
2 the other hand, I am not teaching you anything new when
3 I say that for the past few years the medical class has
4 not had a very good reputation.

5 It is not the only class, but it is one
6 of them in any case. To answer your question more
7 directly, we have given thought to the means to be
8 adopted to attempt to correct this situation, to improve
9 the reputation of our doctors among the general public,
10 and the results of our thoughts are that the best way,
11 the most practical way, to restore a good reputation
12 for doctors is that the doctors should be competent, and
13 that they should know how to assure full sympathy
14 between themselves and their patients. If all the
15 patients are satisfied with all the doctors, their
16 reputation will be restored.

17 From the corrective point of view, we
18 are restricted for the following reason: that campaigns
19 for popular education which might be undertaken by the
20 medical corps are developed in a rather difficult
21 climate, a rather difficult media, if we recognize at
22 this stage that there are certain criticisms directed
23 at our profession. It is difficult to respond thereto
24 by collective action.

25 Attempts have been made in that direction,
26 apparently without any major results. Other things will
27 be attempted very likely in the same objective, but
28 meanwhile our position is still that the best way of
29 rehabilitating our profession is by giving absolutely
30 perfect service, and making ourselves indispensable.

but we have between the medical class and the public on
one other hand. I am not teaching you anything new when
I say that for the past few years the medical class has
not had a very good reputation.

It is not the only class, but it is one
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that they should know how to secure this sympathy
between themselves and their patients. If all the
patients are satisfied with all the doctors, their
reputation will be restored.

From the corrective point of view, we
are satisfied for the following reasons: that campaigns
for popular education which aimed at understanding by the
medical class are developed in a manner difficult
to carry out, a rather difficult matter, as we recognize in
this stage that there are certain conditions which
at our position. It is difficult to respond thereto
by violent action.

Attempts have been made in that direction
and have not been successful. Other things will
be attempted very likely in the same objective, but
the results will be different. We will not give up
the purpose, however, and meeting our ends in this manner.



1 COMMISSIONER BALTZAN: You go on a
2 little bit further in the first part, where you mention
3 that medicine is too costly. By that you mean the
4 total health care program needed for the individual,
5 or for the group, that the whole gamut of medical
6 services is now becoming very high, and perhaps very
7 difficult for a fair number of people, or a fair number
8 of the needy people to obtain.

9 Do you mean total health care, or do
10 you refer to, say, physicians' services?

11 DR. BLAIS: Well, what we meant was
12 all health services. We were not referring only to
13 medical fees of physicians, but we are referring to such
14 matters as hospitalization. In other words, the overall
15 medical care that is offered, that is what we were refer-
16 ring to.

17 COMMISSIONER BALTZAN: Thank you, Dr.
18 Blais. This portion of the physicians' fees is a fraction
19 of the total of health care. Do you happen to have any
20 figures at hand how that fraction of the dollar is in
21 relation to physicians' services?

22 DR. BLAIS: I cannot give you exact
23 figures to answer your question, but according to certain
24 statistics, the cost of medical services and surgical
25 services amounts to about 25% of the total cost. I
26 say this with all due caution, of course.

27 COMMISSIONER BALTZAN: So that would
28 you say that the total health care isn't only a question
29 of the increased cost for physicians and surgeons and
30 specialist service? It is the total picture that is



1 becoming high, and not just this proportion?

2 DR. BLAIS: Yes, we agree on that point.

3 COMMISSIONER BALTZAN: In your total
4 outline, in general principles, you agree to some form
5 of prepaid health services. Do you agree in principle?

6 DR. BLAIS: Yes sir, we agree on that
7 point.

8 COMMISSIONER BALTZAN: And you have
9 delineated that it does not necessarily mean total
10 health services that are going to be prepaid, that it
11 is an optional, or some people that do not want it do
12 not have to subscribe, is that your principle?

13 DR. BLAIS: Yes.

14 COMMISSIONER BALTZAN: You are very good
15 at answering questions just by nodding your head. I
16 heard you repeat that step-by-step things should proceed.
17 Could I take it from that that you do not think that
18 there is any crisis, or emergency approaching for an
19 overall system of medical care, very urgently?

20 DR. BLAIS: Well sir, we must ascertain
21 whether urgent action can yield good results, or whether
22 we should simply limit ourselves to dealing with the
23 urgent side of the question. We agree that there is a
24 certain urgency involved. However, we must keep the
25 results in mind, if because of the urgency in setting up
26 a given plan the results would not be attained, or the
27 results would be jeopardized, we would not have made any
28 progress.

29 In the text submitted this morning we
30 state that all due precaution should be taken to recognize



1 that there is a certain emergency, but at the same time
2 we should proceed progressively, step by step, and not
3 proceed in too brusque a manner, because experience has
4 shown that in certain countries where a scheme has been
5 applied immediately, without sufficient preparation, the
6 success of the experiment has been jeopardized, and we
7 do not want to repeat this sad experience in our own
8 country, but we agree that there is a certain urgency.

9 However, we want valid results, sir,
10 and this presupposes that any scheme should be applied
11 progressively, and not immediately.

dpw 12 COMMISSIONER BALTZAN: Those things
13 that are considered urgent, and progressively other
14 things will be taken up.

15 DR. BLAIS: Yes, this is the manner in
16 which we understand it.

17 COMMISSIONER BALTZAN: Lastly, and this
18 is a very broad question, to get acquainted with the
19 situation in the province, would you say there are many
20 people in very great need who are not receiving adequate
21 medical care and it is because of the cost, the payment
22 for these things - it is inferring that they are suffering
23 on that account, or are most people able to be looked
24 after for their needs in spite of the fact they are not,
25 say, sufficiently covered for their medical needs? Are
26 the people going without medical care because they
27 haven't got the means or money for it?

28 DR. BLAIS: Well, we don't have any
29 statistics on this point. We believe there should be
30 certain people who don't receive necessary care, but it



that there is a certain emergency, but at the same time
we should proceed progressively, step by step, and not
proceed in the haphazard manner, because experience has
shown that in certain countries where a scheme has been
applied immediately, without sufficient preparation, the
success of the experiment has been jeopardized, and we
do not want to repeat this sad experience in our own
country, but we agree that there is a certain emergency.
However, we want valid results, and
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progressively, and not immediately.

that are considered urgent, and progressively rather
things will be taken up.
Mr. BLAIR: Yes, this is the manner in
which we understand it.

COMMISSIONER BALDWIN: Lastly, and this
is a very broad question, to get acquainted with the
situation in the province, would you say there are many
people in very great need who are not receiving adequate
medical care and is because of the cost, the Government
is not taking - it is interesting that they are suffering
or that some of the most people who are in need
after the needs in spite of the fact they are not
any, partially covered for their medical needs. Are
the people going without medical care because they
haven't got the means or money for it?

Mr. BLAIR: Well, we don't have any
statistics on this point. We believe there would be
certain people who don't receive necessary care, but in



1 is quite probable - we don't know, it is quite probable,
2 we don't know the exact percentage of the entire popula-
3 tion that is represented. However, this situation
4 appears in particular regions in the country, in the
5 big urban centres today; I believe that the needs
6 are fairly well covered, but in the more remote regions
7 or more isolated regions, the problem becomes more
8 important because the facilities don't exist, or they
9 exist in a lesser degree.

10 In a city such as Montreal, for example,
11 where there are a great number of physicians and a great
12 number of hospitals the needy cases are rather rare,
13 and they don't suffer from lack of medical services.
14 However, in the remote regions of the country, where
15 there are few physicians available, and where the
16 hospitals are inadequate, the proportion of needy cases
17 could constitute a higher percentage, as we understand
18 it.

19 COMMISSIONER BALTZAN: Thank you very
20 much.

21 THE ACTING CHAIRMAN: Commissioner Van
22 Wart?

23 COMMISSIONER VAN WART: Do you feel
24 that the facilities of the rural districts can be
25 improved by the system?

26 DR. BLAIS: Yes, they could be improved
27 by a new scheme.

28 COMMISSIONER VAN WART: The plan you
29 suggest, would it be practical in the rural districts
30 if the other facilities were not improved?



1 we don't know the exact percentage of the total population
2

3 of which - covered today; I believe that the number
4 are fairly well covered, but in the rural areas, especially
5 in some isolated regions, the population is more
6 important because the facilities for their health exist, or they
7 exist in a lesser degree

8 in a city such as New York, New York, or
9 where there are a great number of physicians and a great
10 number of hospitals, the health care is rather good,
11 and they don't suffer from lack of medical attention.
12 However, in the rural regions of the country, where
13 there are few physicians available, and where the
14 facilities are inadequate, the proportion of people who
15 could receive a higher percentage, as we have found
16

17 that the facilities of the rural areas are not as
18 improved by the government
19

20 Yes, they could be improved
21



1 DR. BLAIS: This plan would give hospi-
2 tal service provided there was a sufficient number of
3 physicians available. This is our viewpoint.

4 COMMISSIONER VAN WART: And hospital
5 access, access to hospitals and so on would be necessary
6 for your plan to work?

7 DR. BLAIS: Obviously in order to meet
8 the needs of the rural regions you would have to deal
9 with the hospital problem. This problem should be
10 studied and an approach should be implemented to this
11 effect.

12 According to our present knowledge
13 the hospitals are filled and the waiting lists are very
14 long even in cities having a great many hospitals, whereas
15 in this new plan we could offer to rural inhabitants
16 greater and more hospital facilities. This is our view-
17 point.

18 COMMISSIONER VAN WART: Thank you.

19 COMMISSIONER FIRESTONE: Dr. Blais, in
20 paragraph B of your submission, the first page, you
21 refer to individuals being entitled to good health. Do
22 you have in mind, and does your Association support the
23 principle that individuals are entitled to the availability
24 of adequate health services to obtain good health?

25 DR. BLAIS: We believe that, as is
26 stated by the World Health Organization today, every
27 person has a certain right to good health. On the basis
28 of this definition of the World Health Organization we
29 agree to recognize that every individual - speaking of
30 social security, has a right to a minimum welfare,

Blais

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and services provided there was a sufficient number of
physicians available. This is our viewpoint.

COMMISSIONER VAN WART: And hospitals?

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the needs of the rural regions you would have to deal

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According to our present knowledge

the hospitals are filled and the waiting lists are very

long even in cities having a great many hospitals, whereas

in this new plan we could offer to rural inhabitants

greater and more hospital facilities. This is our view.

COMMISSIONER VAN WART: Thank you.

Paragraph B of your submission, the first page, you

refer to individuals being entitled to good health. Do

you have in mind, and does your Association mean by the

phrase that individuals are entitled to the availability

of adequate health services to obtain good health?

DR. BLAIS: We believe that, as it

stated by the World Health Organization today, every

person has a certain right to good health. On the basis

of this definition of the World Health Organization we

agree to recognize that every individual - everyone of

social equality, has a right to a minimum welfare.



1 including good health.

2 COMMISSIONER FIRESTONE: I take it the
3 right to good health means that he can get adequate
4 health services, to have somebody look after him when
5 he gets sick, in the hospital or physicians or surgeons
6 or dentists or nurses, what have you - is this what
7 you mean by right to good health, that he could go and
8 obtain those services irrespective as to whether he can
9 pay for it or not? Is that what you mean, sir?

10 DR. BLAIS: Well, we mean two things,
11 sir, as is stated further in the text. The right to
12 good health for the individual implies his own willing-
13 ness to co-operate, collaborate. With respect to
14 prophylactic medicine the individual has a right to good
15 health, but he also must make an effort to obtain health.

16 If he does collaborate he does have the
17 right to the availability of medical services and
18 medical care.

19 From another point of view, if we
20 limit ourselves to giving the individual medical care
21 without dealing with prophylactic medicine, I don't
22 believe the problem would be solved.

23 COMMISSIONER FIRESTONE: That is a good
24 point, Dr. Blais. I take it, then, the need of Canadians
25 to realize this right to good health can be achieved by
26 providing a national plan that will provide the facilities
27 across the country to obtain such health services. Is
28 that what you have in mind, sir?

29 DR. BLAIS: No sir, it is not exactly
30 what we have in mind. You are speaking of a national



CONFIDENTIAL: I take it the

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he goes sick, to the hospital or physician or surgeon
or dentist or nurse. What have you - is this what
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out to these services irrespective as to whether he can
pay for it or not? Is that what you mean, sir?

DR. BLAIR: Well, we mean two things,
one, as is stated further in the text, the right to
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ness to co-operate, collaborate. With respect to
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From another point of view, if we
aim ourselves at giving the individual medical care
without dealing with a prophylactic medicine, I don't
believe the problem would be solved.

CONFIDENTIAL: I take it, then, the need of Canadians
to realize this right to good health can be achieved by
providing a national plan that will provide the facilities
across the country to obtain such health services, so
that when you have to work, sir?

DR. BLAIR: Well, it is not exactly
what we have in mind, you are speaking of a national



1 plan and we have in mind a provincial plan.

2 COMMISSIONER FIRESTONE: That is very
3 helpful. Looking at the province, if one province, I
4 presume you speak for the French-speaking members
5 operating in all provinces of Canada, or nearly all, as
6 you say, and therefore you are concerned with a plan
7 that would be applicable in each province, is that
8 correct?

9 DR. BLAIS: Well, yes, sir, taking
10 account, of course, of the fact that the needs of
11 provinces differ with respect to different regions of
12 the country involved.

13 COMMISSIONER FIRESTONE: I accept that,
14 Dr. Blais, and it is a useful comment. I take it from
15 what you say that you are in favour of ten provincial
16 plans, so that everyone in Canada would be able to
17 realize the objective of the right to good health; is
18 that correct, sir?

19 DR. BLAIS: Oh yes, this corresponds
20 to our idea.

21 COMMISSIONER FIRESTONE: Now, sir, will
22 you have ten different provincial plans or would you
23 have - would you be in favour of plans which provide a
24 minimum standard in all health services in every province
25 in Canada?

26 DR. BLAIS: Well, I think it would be
27 possible for the provinces to agree amongst themselves
28 to set up a minimum number of medical services, as you
29 stated, but they should retain their autonomy. On
30 this point, the provinces show some inclination to



plan and we have in mind a provincial plan.

COMMISSIONER FISHBONE: That is very

helpful, bearing in mind the province, in one province, I

presume you speak for the French-speaking members

operating in all provinces of Canada, or nearly all, as

you say, and therefore you are concerned with a plan

that would be applicable in each province, is that

correct?

account, of course, of the fact that the needs of

provinces differ with respect to different aspects of

the country involved.

COMMISSIONER FISHBONE: I accept that.

Dr. Blais, and it is a useful comment. I take it from

what you say that you are in favour of two provincial

plans, so that everyone in Canada would be able to

realize the objective of the right to good health; is

that correct, sir?

Dr. BLAIS: Oh yes, this corresponds

to our idea.

COMMISSIONER FISHBONE: Now, sir, all

you have two different provincial plans or would you

have - would you be in favour of that which would provide

uniform standards in all health services in every province

in Canada?

Dr. BLAIS: Well, I think it would be

possible for the provinces to agree amongst themselves

to set up a minimum number of medical services, as you

stated, but they should retain their autonomy, on

this point, the provinces show some inclination to



1 discuss other problems at the present time, and this
2 problem could also be discussed by the provinces..

3 COMMISSIONER FIRESTONE: You appreciate,
4 Dr. Blais, the necessity of providing for minimum stan-
5 dards of health services across Canada, in order not to
6 limit the mobility of the Canadian population, of people
7 moving from one area to another, it is an important
8 factor in our economic development that people can move
9 from one province to another, and if there weren't a
10 minimum plan across the country it would affect that
11 mobility, and therefore, if I understand you correctly,
12 you feel as a desirable objective such minimum standards
13 should be worked out in one form or another; is that
14 correct, sir?

15 DR. BLAIS: We believe that this plan
16 could be implemented, but at the provincial level, so
17 that the provinces can agree to provide minimum standards
18 with respect to health services.

19 COMMISSIONER FIRESTONE: Well, I accept
20 your premise, Dr. Blais; these plans should be provin-
21 cially administered, and that the plans organized on a
22 provincial basis, run by a provincial commission with
23 participation of various groups, and adjusted to the
24 needs of the people in each province.

25 Assuming this basis of such a plan, you
26 would still feel there should be certain minimum standards
27 across the country, so that people could move from one
28 area to another and not be penalized for moving from
29 one province to another; is that the way you favour it?

30 DR. BLAIS: Yes, we agree to that.



discuss other problems at the present time, and this problem could also be discussed by the Government.

Dr. Blais, the necessity of providing for minimum standards of health services across Canada, in order not to limit the mobility of the Canadian population, of people moving from one area to another, it is an important factor in our economic development that people can move from one province to another, and if there were a minimum plan across the country it would affect that mobility, and therefore, if I understand you correctly, you feel as a desirable objective such minimum standards should be worked out in one form or another, is that

DR. BLAIS: We believe that this plan could be implemented, but at the provincial level, so that the provinces can agree to provide minimum standards with respect to health services.

Your question, Dr. Blais; these plans should be provincially administered, and that the plans organized on a provincial basis, run by a provincial commission with participation of various groups, and referred to the needs of the people in each province.

Assuming this basis of such a plan, you would still feel there should be certain minimum standards across the country, so that people could move from one area to another and not be hampered for moving from one province to another; in that case, you favor it?

DR. BLAIS: Yes, we agree to that.



1 COMMISSIONER FIRESTONE: Now, sir, as
2 I understood you, you are visualizing such a plan which
3 would be applicable to every province in Canada to be
4 financed in part by the contribution of individuals.
5 I take it you have in mind the payment of premiums?

6 DR. BLAIS: Yes, sir.

7 COMMISSIONER FIRESTONE: And you have
8 also in mind those who are in low income groups and
9 that couldn't pay any premiums, that that premium be
10 paid by the State?

11 DR. BLAIS: Yes sir.

12 COMMISSIONER FIRESTONE: And then, you
13 have mentioned a certain group, and these are people
14 that have low incomes and can afford a modest premium,
15 but not the full premium, and the difference should be
16 paid by the State?

17 DR. BLAIS: Yes, sir.

18 COMMISSIONER FIRESTONE: I take it,
19 then, that this plan in each province would be financed
20 A, through premium payments and B, through contribution
21 by government; is that correct?

22 DR. BLAIS: From the Provincial Govern-
23 ment.

24 COMMISSIONER FIRESTONE: Well, sir, do
25 I understand that in case these financial contributions
26 required from the Provincial Government turn out to be
27 very large, that you would have no objection to the
28 Federal Government making contribution to a provincial
29 scheme, provincially-administered.

30 DR. BLAIS: In principle, sir, we feel



1 in such a plan a new arrangement of the fiscal charges
2 and new distribution of income revenue and for this
3 reason we decided to proceed progressively. At the
4 present state of affairs we feel that the provinces
5 couldn't afford to implement a program of this scope.

6 However, we should consider the possibi-
7 lity of revising the fiscal charges before undertaking
8 the expenditure, as is stated in the brief before the
9 Commission. Before deciding on several million dollars
10 expenditure we should first ascertain who will pay this
11 expenditure and how it will be paid.

12 COMMISSIONER FIRESTONE: Well, that is
13 a very wise and cautious method, Dr. Blais. I take it
14 from the way you are suggesting it, you are in favour
15 of a purely provincially-financed plan and provincially-
16 operated plan, but would you feel that if the provinces
17 are unable to pay for that plan themselves, that is the
18 contribution which they make, that you could visualize
19 a federal contribution being made to a provincially-
20 operated plan?

21 DR. BLAIS: Sir, if a particular
22 province is unable to finance the medical service plan
23 it will be free to study the problem and decide where
24 it can obtain the necessary money, but as a whole, sir,
25 in general, we recognize that this is a matter for the
26 Provincial Government and it should remain as such.

27 In those provinces that have too little
28 revenue to finance such a plan it may be that these
29 provinces, because of their relatively low population,
30 will have a proportionately lesser expenditure. The



1 more expenses a province has the greater its population.

2 We attach great importance to the
3 principle of holding this scheme within the provincial
4 jurisdiction, but we are not legislators, sir, we are
5 physicians. In the future, each province will have to
6 study the cases that arise in the course of its experience.
7 Our position is based simply on a general position
8 involved.

9 COMMISSIONER FIRESTONE: You are quite
10 right, Dr. Blais; you are physicians and you are concerned
11 largely and mainly with the health of the people in
12 Canada. We are coming to you for some advice of how
13 such health services can be made available to everybody
14 in Canada along the line which you have suggested.

15 Taking into account the constitutional
16 division of responsibility between the Federal Government
17 and the Provincial Government, may I come back to the
18 point, I am trying to be enlightened by yourself: I
19 think you have made a strong case for the desirability
20 of a provincially-operated scheme and financed partly by
21 premiums and partly by general revenue by provinces
22 which a province will try to collect the best way it
23 sees feasible, but you know, sir, there are provinces
24 with a higher level of income and there are provinces
25 with lower levels of income, and provinces with lower
26 levels of income, they find difficulty to finance the
27 services at a given minimum level, and they have required
28 financial assistance from the Federal Government.

29 This has been the history from confederation
30 since 1867, and therefore if we are taking on a plan such



1 as you propose, which should be introduced in every
2 province in Canada, to be available to all Canadians,
3 we must have a plan that will make available financial
4 means to implement the plan in the wealthy province as
5 well as the provinces that are not as well off, and
6 therefore we have to think of an overall plan that makes
7 these means available to every province.

8 Therefore, my question is this, Dr.

9 Blais: if the Federal Government introduces legislation
10 to the Federal Parliament offering those provinces that
11 wish to participate in a medical care plan across the
12 country, that they would pay 50% of the cost of such a
13 plan, similar to what is presently in operation in the
14 hospital insurance field, leaving it to each province
15 to decide whether they want to avail themselves of the
16 system or not - if a province is so rich it doesn't
17 need the money, bless them --but supposing there are
18 provinces that do want to avail themselves, would you
19 be in favour of such a plan? as to make a decision as to
H/dpw 20 whether a province wishes to avail themselves of finan-
21 cial assistance or not but it would be a national fund
22 that would be made available for that purpose. How do
23 you feel about this?

24 DR. BLAIS: Well, that is rather a
25 tricky question. Some problems exist at other levels,
26 for instance, at the level of the hospital insurance
27 scheme. However, the problem could be considered in
28 the manner we have just stated, namely, we recognize at
29 the present time that the distribution, the fiscal
30 charges, should be left as they are but we feel that a



1 province which may ask for federal subsidies to organize
2 medical services will, of course, have the right to do so.

3 However, before asking for this, if
4 the province has sufficient income deriving from its
5 own taxation, then it would not need to ask for such
6 subsidies. It is a matter of federal financing but also
7 it concerns the aspect of jurisdiction.

8 If the fiscal arrangements could be so
9 modified as to give each province the possibility of
10 organizing its own medical services then it could do
11 without such assistance.

12 COMMISSIONER FIRESTONE: I am just
13 wondering a little whether a question that tries to
14 establish how one can provide for Canada a plan or program
15 that provides health services to everybody is really a
16 tricky question. I leave this to your own good judgment.

17 My point still remains that we would
18 like an answer from you whether you are in favour of a
19 federal offer to the province to participate in provin-
20 cial plans financially? If you wish you can say yes or
21 no or you could say you have no views on the matter.

22 DR. BLAIS: Well, I can say no but I
23 can also say that at the present time we believe that
24 health services falling within the jurisdiction of the
25 province should be upheld. Secondly, if the Federal
26 Government were to offer a plan for financial contribution
27 to be made to the province then it would be up to the
28 province to accept or refuse but those provinces which
29 would refuse would be penalized because these expendi-
30 tures would be financed by their taxes so that certain



1 health services could be paid by the provincial taxes.

2 Now, you ask me to reply yes or no.

3 COMMISSIONER FIRESTONE: No sir, I do
4 not say yes or no, I said yes or no or you may have no
5 views on the subject. You may feel free to give any
6 answer you wish; it is just that you deal with the
7 question.

8 DR. BLAIS: I have an idea on this
9 point and it is for that reason that I said no.

10 COMMISSIONER FIRESTONE: We would be
11 happy to have your ideas on this point.

12 Now, may I turn to another question
13 as to how the plan would operate. I understand you are
14 in favour of a Commission that would administer the
15 plan?

16 DR. BLAIS: I have ideas that the
17 federal plan should be administered by a provincial
18 Commission which should be composed of persons represen-
19 ting the interests of various classes of society; that
20 is the way we envisage setting up the Commission.

21 COMMISSIONER FIRESTONE: The Commission
22 would represent members of labour, agriculture, consumers
23 and other groups and representatives of the Provincial
24 Government?

25 DR. BLAIS: We envisage the setting up
26 of an organization of that kind in which there would be
27 representatives of all classes of industry, finance and
28 the Government itself in addition.

29 COMMISSIONER FIRESTONE: Do you include
30 labour?



health services could be paid by the provincial treasury.

Now, you ask me to reply yes or no.

COMMISSIONER FIRSTSTONE: No sir, I do

not say yes or no, I said yes or no or you may have no

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MR. BLAIR: We envisage the setting up

of an organization of that kind in which there would be

representatives of all classes of industry, commerce and

the Government itself in addition.

COMMISSIONER FIRSTSTONE: Is that correct?

Labour



1 DR. BLAIS: Yes, labour also and the
2 unions.

3 COMMISSIONER FIRESTONE: Fine. Now,
4 how would this Commission pay doctors' bills? How
5 would this system operate? When a doctor sees a patient
6 would he then bill the Commission? How would the system
7 work?

8 DR. BLAIS: That is a very precise
9 question which involves actual methods of operation and
10 we have not gone as far as to study the actual methods
11 of payment. This would have to be reviewed. We wonder
12 whether in the climate in which we live as physicians
13 that we are really able to give our opinions - we may
14 have more precise views, I have not given them, I cannot
15 answer the question precisely at this stage.

16 COMMISSIONER FIRESTONE: I am really
17 not looking for a precise answer but just a general
18 understanding. There are two ways in which you could
19 bill a patient, either you send the bill to the patient
20 and he sends it on to the Commission or you bill the
21 Commission itself; how does it work now?

22 DR. BLAIS: Well, two methods may
23 apply, it depends on the extent of the insurance plan;
24 if it is paid by the insurance companies; whether the
25 physician is a participant. In a plan of this scope
26 we have to consider the scope of operation and perhaps
27 from the point of view of principle it would be better
28 for the doctor to have his fee paid by the patient but
29 perhaps there would be objection because that would
30 cause a great deal of red tape to pay the patient and



1 then he would pay the doctor. Perhaps the Commission
2 would welcome the system of paying the doctor but that
3 is a question which we have not gone into in full detail.
4 Personally I think that the two methods are envisaged.

5 COMMISSIONER FIRESTONE: Then I take it
6 that the direct payment by the Commission to the doctor
7 would be the more efficient system?

8 DR. BLAIS: I am not in a position to
9 answer that, sir, but there is a question of accounting
10 and a question of technique. I imagine, however, that
11 for the Commission it would be simpler that way.

12 COMMISSIONER FIRESTONE: Let us assume
13 that after studying this it is proven this is a more
14 efficient system, would you feel that the fact that the
15 Commission pays the doctor's bill that this interferes
16 with the doctor-patient relationship?

17 DR. BLAIS: If that applies to the
18 medical act, medical act and treatment, then I think we
19 can accept that method.

20 COMMISSIONER FIRESTONE: I take it you
21 feel it would not interfere with the doctor-patient
22 relationship?

23 DR. BLAIS: Well, I do not want to be
24 made to say what I do not want to say but if I may I
25 will make a distinction here; I think that doctors
26 generally are willing to receive payment in part which
27 is a system of insurance plans, prepaid plans. Generally
28 if we admit that medicine will not become a State matter
29 I think the relationship between patients and the physi-
30 cian will be safeguarded but if you had a way of doing it



1 gradually that medicine will be a State matter then I
2 think the relationship will be falsified.

3 Then, in the presentation I have made
4 I have attempted to submit the facts that State - that
5 medicine, establishment of State medicine, is against
6 the relationship of patient and physician.

7 COMMISSIONER FIRESTONE: Would payment
8 to the physician directly affect the quality of the
9 medical treatment the patient would receive?

10 DR. BLAIS: If the payment is for the
11 actual treatment I do not think it will affect the
12 relationship between the patient and doctor.

13 COMMISSIONER FIRESTONE: Therefore would
14 I be right in concluding that the method of payment
15 does not affect the quality of the medical service as
16 long as the doctor is paid a proper fee on a fee-for-
17 service basis?

18 DR. BLAIS: I would not be prepared to
19 give an official answer from that point of view, every-
20 thing would depend on the medical knowledge, science,
21 the principles. We might perhaps admittedly have every-
22 thing costing so much that the payment is made according
23 to the treatment, the relationship between the doctor
24 and patient will have to be modified. It would be neces-
25 sary to say there is no interference on the part of the
26 Government in the exercise of the medical profession.

27 COMMISSIONER FIRESTONE: You also make
28 a suggestion that such a program could be proceeded with
29 in stages; could you tell us what specific stages you
30 had in mind in implementing the program you have proposed?

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to the treatment, the relationship between the doctor

and patient will have to be defined. It would be neces-

sary to say there is no interference on the part of the

Government in the exercise of the medical profession.

COMMISSIONER FRISTON: You also wish

a suggestion that such a program could be presented with

in cases, could you tell us what facilities suggest you

had in mind in implementing the program you have proposed?



1 DR. BLAIS: We state in our text that
2 we recommend that the procedure be by stages. I think
3 that if a priority were exercised in the organization
4 of such a plan the plan would first have to meet the
5 most urgent requirements amongst us. You realize the
6 fact that some people cannot get medical care because
7 they are needy and by priority they should be the first
8 to be served.

9 Now, when we mention that the plan
10 might be established in stages we considered that the
11 establishment and minimum implementation of the whole
12 plan would perhaps jeopardize the good sense of that -
13 I think that is what we mean by stages.

14 COMMISSIONER FIRESTONE: I was trying
15 to visualize what you would have in mind for the first
16 stage. Would you have in mind for the first stage the
17 introduction of a plan such as you have spoken of on a
18 voluntary basis whereby people that cannot afford to pay
19 the premium have the premium paid for them by the State;
20 those who can afford to pay part, the balance is paid
21 and the remainder of the population who can afford to
22 pay do so; is that your plan?

23 DR. BLAIS: That would correspond with
24 our views.

25 COMMISSIONER FIRESTONE: The next
26 question is, you have outlined requirements for implemen-
27 ting the plan, three requirements, and you state it
28 should be based on logic, sincerity and foresight; would
29 you add a fourth requirement, co-operation?

30 DR. BLAIS: With great pleasure, only



DR. HAYES: We state in our terms that we recommend that the procedure be as simple. I think that if a priority were exercised in the organization of such a plan the plan would have to meet the most urgent requirements amongst us. You realize the fact that some people cannot get medical care because they are needy and by priority they should be the first.

Now, when we mention that the plan might be established in stages we considered that the establishment and minimum implementation of the whole plan would perhaps jeopardize the good sense of that. I think that is what we mean by stages.

COMMISSIONER FLEISHER: I was trying to visualize what you would have in mind for the first stage. Would you have in mind for the first stage the introduction of a plan such as you have shown of on a voluntary basis whereby people that cannot afford to pay the premium have the premium paid for them by the State; those who can afford to pay now, the balance is paid and the remainder of the population who can afford to pay do so is that your plan?

DR. HAYES: That would be covered with our terms.

COMMISSIONER FLEISHER: Yes, next question is, you have outlined requirements for implementation of plan, three requirements, and you state it should be based on logic, efficiency and feasibility, would you add a fourth requirement, cooperation?

DR. HAYES: With great pleasure, yes.



1 we thought that it was not necessary to mention because
2 it was an unnecessary condition. Sincerity itself, of
3 course, includes co-operation to some extent, on one
4 side or the other and that is why we did not think it
5 necessary to include it in the brief.

6 COMMISSIONER FIRESTONE: I am happy to
7 hear you say in the Province of Quebec co-operation is
8 taken for granted; in other provinces it is not. Thank
9 you very much.

10 THE ACTING CHAIRMAN: There is just one
11 matter I would like to clear up in my own mind. You
12 were a little concerned, as I thought, about some of
13 the questions that Dr. Firestone put to you with respect
14 to the possibility of a federal plan being instituted
15 in which the provinces could participate.

16 Is your concern that if the Federal
17 Government were to say under certain circumstances if a
18 province wished to introduce a medical care plan they
19 would contribute a certain percentage to it that if a
20 number of provinces participated then the pressure on
21 the other provinces, whose population would be contribu-
22 ting to the federal plan through the taxes they paid to
23 the Federal Government, would become irresistible and
24 the provinces who stayed out, let us say the Province
25 of Quebec who remained out of hospital insurance for a
26 long time, would be forced by that pressure, the popula-
27 tion saying "We are paying for something and not getting
28 it".

29 The Provincial Government would enter
30 into a scheme, the ground rules of which were laid down



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 taken for granted; in other provinces it is not. Thank
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 it.

The Provincial Government would have
 into a scheme, the ground rules of which would be down



1 by the Federal Government and that would be an indirect
2 invasion by the Federal Government into the provincial
3 field of health. Is that your basic objection?

4 DR. BLAIS: Yes, Mr. Chairman, that is
5 what happened in the past and we prefer it should not
6 occur in the future. As we have had an opportunity of
7 mentioning earlier, instead of imposing upon a province
8 a plan by presenting the possibility of a certain amount
9 of money being supplied by the centre of government
10 it would be preferable to give that province a share of
11 taxation revenue which would permit it itself to organize
12 its health services and then not need the help of the
13 Federal Government to organize it. That is our view on
14 that point.

15 We know that in the past what you have
16 just described has occurred in other connections, but
17 we should prefer a redistribution of the tax wealth,
18 which would permit each province to have its own service.
19 Does that answer your point, Mr. Chairman?

20 THE ACTING CHAIRMAN: Yes, I would
21 like to ask just one more question. Assuming this
22 redistribution of tax sources to which you refer, can
23 you visualize a situation where one province might say:
24 "Well, we have even more important priorities than a
25 prepaid health scheme, and we will devote our funds to
26 that."

27 Is it your view that each province
28 should independently, without any indirect coercion,
29 make up its own mind on these matters that are within
30 its jurisdiction?



1 DR. BLAIS: Mr. Chairman, we mentioned
2 earlier that it might be an excellent thing for the
3 provinces to consult between themselves in the organiza-
4 tion of the provincial health plans, and I think that
5 we should not accept here any idea of coercion.

6 This is always a bad starting point.
7 Rather than to see a distribution of funds by the
8 Federal Government to the provinces, I repeat, it seems
9 more in order to us that the provinces should discuss
10 between themselves, and agree to establish a minimum of
11 medical services within each of them, which means that
12 throughout Canada following that there would be a minimum
13 of medical service available to individuals.

14 THE ACTING CHAIRMAN: Well, that might
15 be ideal, but I say, can you visualize a situation where
16 you would not reach such an agreement, and where one
17 province might decide to spend its money on roads, and
18 another might decide to spend its money on health care.

19 Are you prepared to leave this decision
20 to the province?

21 DR. BLAIS: I think so, Mr. Chairman.
22 If we recognize that the Constitution grants privileges
23 to the provinces, we also have to recognize that they
24 are entitled to make use of those privileges, and I
25 don't think that unless the Constitution were changed
26 it would be possible to force a project upon a province
27 in that field.

28 COMMISSIONER FIRESTONE: As doctors,
29 would you not feel that the province that does not under-
30 take to provide for adequate medical care services in the



1 province, that you would hope that that province can
2 be persuaded to provide such services?

3 Now you are talking as doctors, and
4 not as politicians.

5 DR. BLAIS: They might perhaps be
6 persuaded to do so by the sister provinces, or by the
7 local counsellors, or persons that have experience in
8 the local authority.

9 I would prefer that the persuasion to
10 enter such a plan be by the Federal Government.

11 COMMISSIONER FIRESTONE: Would there
12 be anything wrong with persuasion by doctors to intro-
13 duce a scheme of comprehensive health services in the
14 province, as a contributory factor?

15 DR. BLAIS: Of course, the doctors may
16 propose changes, reforms. That has occurred and it is
17 still occurring, but the provincial legislators still
18 have the right to accept or not to accept such proposals,
19 and this still occurs.

20 But I think that if the medical body
21 presents to the Legislature precise arguments, there are
22 reasonable chances for their opinions to be followed.

23 THE ACTING CHAIRMAN: Thank you very
24 much, Dr. Blais. Have you or your associates anything
25 else that you would like to add at this time?

26 DR. LEGER: In the alternative which
27 the Chairman suggests, would it not be possible that in
28 certain cases a province might find another project more
29 urgent, precisely because its population would not at
30 that time have any deficiency in medical services? This



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2 be persuaded to provide such services.
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16 propose changes, reforms. That has occurred and it is
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19 and this still occurs.

20 But I think that in the medical body
21 presents to the legislature practical arguments, there are
22 reasonable chances for their opinions to be followed.
23 THE ACTING CHAIRMAN: Thank you very
24 much, Dr. Blair. Have you or your associates anything
25 else that you would like to add at this time?

26 DR. HUGHES: In the legislative union
27 the various provinces, would it not be possible that in
28 certain cases a province might find another province more
29 likely, precisely because its population would not be
30 what time have any difficulty in medical services. This



1 is the reason why I think it might not be possible, or
2 desirable indeed, to impose indifferently upon each
3 legislature certain conditions, whereas the needs might
4 not be in line.

5 I think that probably you have raised
6 the question having in mind that in the province you
7 took the population might in fact be suffering from
8 inadequacy of health services, but it is quite possible
9 that you meant that in the province in question the
10 medical services, being normally insured, other projects
11 might be more urgent.

12 In that last alternative I think that
13 we would have a flagrant case of imposition upon a
14 legislature of projects which would not be necessarily
15 the most urgent and essential projects. Because of that
16 possibility, I don't think it would be desirable for a
17 central power indifferently to impose on all provinces
18 the same conditions.

19 That is the possibility I want to make,
20 because of a province which considers a project which
21 might be more urgent.

22 THE ACTING CHAIRMAN: Thank you very
23 much, Dr. Leger. Has anyone else any comments to make?
24 If not, thank you very, very much, gentlemen for coming
25 here this morning. We appreciate your views, and they
26 will receive careful consideration.

27 I should have said at the opening that
28 there will be some 28 representations made to us at
29 these sittings, which will carry through until Tuesday
30 of next week, and at the conclusion of the representations



1 of which we have already had notice, if there is any
2 person who wishes to address himself, or herself, to
3 the Commission, why we will be prepared to hear those
4 further representations.

5 Thank you gentlemen, we will take a
6 short break.

7
8 --- Short Recess
9

10 THE ACTING CHAIRMAN: Ladies and gentle-
11 men, if we can come to order the next submission is that
12 of the Montreal Dental Club. Would the Chairman introduce
13 himself and his associates?

14 SUBMISSION OF THE MONTREAL DENTAL CLUB

15 Appearances: Dr. F. Owen Frederick,
16 President
17 Dr. Austin W. Oliver,
18 Vice-President
19 Dr. D. Bruce Ward
20 Dr. Howard T. Oliver
21 Dr. Archibald F. Cameron
22 Dr. R. LeBlanc

23 DR. FREDERICK: Mr. Chairman, I am the
24 President of the Montreal Dental Club. I would like to
25 introduce my colleagues. On my right is Dr. Howard
26 Oliver; the next is Dr. Austin Oliver; Dr. D.B. Ward;
27 Dr. A.F. Cameron, and Dr. LeBlanc, from the provincial
28 College of Dental Surgeons, the Registrar.

29 THE ACTING CHAIRMAN: Would you like
30 to proceed with your submission then, Dr. Frederick?
This brief will be known as Exhibit 212.

--- EXHIBIT NO. 212: Submission of the Montreal Dental Club.

of which we have already had notice, it is now a day

the Commission, why we will be prepared to have those

Thank you gentlemen, we will take a
short break.

--- Sir's House

THE ACTING CHAIRMAN: Ladies and gentlemen,
men, if we can come to order the next question is that
of the National Mental Clinic. Would the Chairman introduce
himself and his associates?

SUBMISSION OF THE NATIONAL MENTAL CLINIC

Vice-President

Dr. Howard T. Oliver

Dr. R. L. Bell

DR. PRESIDENT: Mr. Chairman, I am the
President of the National Mental Clinic. I would like to
introduce my colleagues. On my right is Dr. Howard
Oliver; the next is Dr. Assistant Oliver, Dr. E. B. Ward;
Dr. A. F. Carter, and Dr. Leonard, from the National
College of Mental Diseases, the Registrar.

THE ACTING CHAIRMAN: Would you like

to proceed with your association, Dr. President?
This paper will be known as Exhibit 2A.



1 THE ACTING CHAIRMAN: If you would like
2 to deal with your summary and recommendations, and then
3 if you or any of your colleagues would like to amplify
4 anything before we start the questioning period, please
5 feel free to do so.

6 DR. FREDERICK: With your permission,
7 Mr. Chairman, I would like to give you a brief background
8 of the organization we represent. The membership of
9 the Montreal Dental Club consists of 214 practising
10 dentists, almost entirely graduates of McGill University.

11 57 are on the attending staff of the
12 Montreal General Hospital. Five are on the attending
13 staff of the Royal Victoria Hospital. Three are on the
14 attending staff of the Queen Mary Veterans' Hospital.
15 Two are on the staff of the Verdun Protestant Hospital,
16 four at the Shriners' Hospital for Crippled Children.
17 75 served in the active forces.

18 To ensure the maintenance of a high
19 standard of dentistry in our province, each October for
20 the past 36 years, we have presented a three-day clinic,
21 which is internationally known for its high calibre.

22 We are not here as experts in the field
23 of public health, or administration, but solely as
24 representatives of a group of men and women in the
25 private practice of dentistry, and as such we present
26 our views.

27 I would like to read the summary of
28 our brief:

29 Mr. Chairman, members of the Royal
30 Commission on Health Services:



1 Permit us to say first that as dentists
2 we are dedicated to the improvement and maintenance of
3 oral health of our fellow Canadians and that with this
4 in mind we present the plan which we believe to be:

5 a) the most progressive, efficient

6 and democratic for providing the

7 greatest amount of good dentistry

8 to the most Canadian people;

9 b) a plan which has raised the

10 standard of dentistry in North

11 America to the highest in the world;

12 c) a plan which allows freedom of

13 choice to the public and the dentist;

14 d) a plan which allows the dentist

15 to operate at his moral best;

16 e) a plan under which all our obser-

17 vations confirm that the poor fare

18 better than when under a state

19 controlled scheme;

20 f) a plan which encourages students

21 to enter the dental profession;

22 g) a plan which is the least expen-

23 sive per unit of work;

24 h) in brief, it is the plan of

25 dentistry working under free enter-

26 prise.

27 We ask for no government subsidies,

28 but we do recommend encouragement of students to enter

29 the dental profession through assurance that the dentist

30 will retain his rights as an individual and not be



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 we are dedicated to the improvement and maintenance of
 oral health of our fellow Canadians and that with this
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 to secure the dental profession;
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 sive per unit of work;
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We ask for government subsidies
 not to do a commercial arrangement in order to be enter-
 the dental profession through a measure that the public
 will receive the right as an individual and not be



1 regimented.

2 We recommend fluoridation of communal
3 water supplies, reduced use of cariogenic agents, and
4 the promotion of good oral hygiene.

5 That is our summary, Mr. President.

6 THE ACTING CHAIRMAN: Is there anything
7 you would like to add, Dr. Frederick, anything you
8 would like to expand on any of these points, or any
9 of your colleagues would like to add anything?

2 10 DR. FREDERICK: Mr. President, I think
11 we will wait for any questions which your Committee
12 care to ask.

13 COMMISSIONER STRACHAN: Gentlemen, even
14 though your brief was impregnated with interrogation,
15 I am sure you realize that it must be our turn to interro-
16 gate, and possibly I am going to put last things first,
17 by referring to, and hoping that you will straighten
18 us out on your intention.

19 You have, in the last paragraph, both
20 in your summary and in the body of the brief, added:
21 "Needless to say we still recommend: (a) this preventive
22 measure; (b) along with others, such as the reduction of
23 the consumption of cariogenic agents for those suscep-
24 tible to caries, and, (c) the promotion of good oral
25 hygiene habits."

26 You have suggested many things should
27 not be done. These are your suggestions of what should
28 be done. Where do you place them in your thinking?

29 DR. FREDERICK: I think, Dr. Strachan,
30 that the point you have made of bringing item 34 to the



We recommend elimination of commercial

water supplies, reduced use of carcinogenic agents, and

the promotion of good oral hygiene.

That is our summary, Mr. President.

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you would like to add, Dr. Friedman, anything you

would like to expand on any of these points, or any

of your colleagues would like to add anything?

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we will wait for any questions which your Committee

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though your brief was interpreted with interpretation,

I am sure you realize that I must be one turn to inter-

pose, and possibly I am going to ask you a question first,

by referring to, and hoping that you will correct

us out of your attention.

I have, in the last paragraph, both

in your summary and in the body of the report, asked:

"Needless to say we still recommend: (a) this preventive

measure; (b) along with others, such as the reduction of

the consumption of carcinogenic agents for those suscep-

tible to cancer, and (c) the promotion of good oral

hygiene habits.

You have suggested many things should

not be done. There are your suggestions at what should

be done. Would you place them in your summary?



1 front is well taken. We believe that the preventive and
2 educational aspects of this problem are the most impor-
3 tant single fact. The matter of public education in
4 oral hygiene, and the matter of any preventive methods
5 we can find are the most important single factors that
6 we can conceive of in the problem of dental health.

7 COMMISSIONER STRACHAN: You do agree
8 then that they are of the first and foremost importance,
9 rather than the negative approach?

10 DR. FREDERICK: I believe so.

11 COMMISSIONER STRACHAN: Then would that,
12 in your opinion, be the best approach to improving the
13 dental health of the nation, or should I say the best
14 initial approach?

15 DR. FREDERICK: I was going to say I
16 would agree that it would be the best first approach,
17 and it is absolutely essential, we believe.

18 COMMISSIONER STRACHAN: Would your
19 organization, the Montreal Dental Club, be in favour of
20 a voluntary prepayment plan operated by an insurance
21 company, or a professional association, and what condi-
22 tions would you insist on?

23 DR. FREDERICK: I am going to ask Dr.
24 Ward to answer that, if I may?

25 DR. WARD: Mr. Chairman and gentlemen,
26 with these prepayment plans I would say that we are
27 certainly in favour of any situation that would provide
28 more good dental service for more people at a reasonable
29 expenditure, but as we see them today, none of the
30 prepayment plans are really good, because they are



1 primarily treatment plans, and it is our feeling that
2 treatment is certainly no answer to the dental ills of
3 the country. We again stress the importance of patient
4 education, preventative methods, as our primary targets.

5 COMMISSIONER STRACHAN: You have said
6 in paragraph 18:

7 "We recommend a plan under which
8 all our observations confirm that
9 the poor fare better than when
10 under a State-controlled scheme."

11 In this respect may I ask how do people
12 who cannot afford the dental services now get care, and
13 what agencies, facilities or means now exist for the
14 treatment of indigent or partial income groups?

15 DR. H.T. OLIVER: Well, at present,
16 not only are there clinics available in the hospitals
17 and universities, but there are also municipal clinics,
18 and we have public health dentists in the Province of
19 Quebec who also run clinics for the province under
20 those conditions.

21 But here again, to revert to our major
22 premise, it is a physical impossibility for us to look
23 after, unfortunately for us to look after all these indi-
24 gents on a treatment basis, and that is the reason that
25 we wish to stress this preventative method to stop this
26 caries before the onset of it begins, to use the methods
27 recommended.

28 COMMISSIONER STRACHAN: You refer to
29 public health dentists; do they do any operating or are
30 they entirely concerned with education?



1 DR. H.T. OLIVER: They are concerned,
2 to the best of my ability - I don't profess to know -
3 I think they are mostly in the educational field.
4 There are some clinics run by the public health dentists.
5 I believe there are dentists employed by them in the
6 Province of Quebec.

7 COMMISSIONER STRACHAN: You mentioned
8 hospitals; to what extent do dental clinics exist in
9 hospitals in the province?

10 DR. H.T. OLIVER: Well, dental clinics
11 which we are familiar with in the City of Montreal, open
12 to indigents and acute pain and so forth and others who
13 require treatment, they are going constantly. There is
14 no shortage of work to be done as far as the thing is
15 concerned. Mostly pain brings them to the hospital.

16 COMMISSIONER STRACHAN: Are there many
17 hospitals which have dental clinics?

18 DR. H.T. OLIVER: The Montreal General
19 Hospital has, of course, a dental teaching clinic. The
20 Royal Victoria has a clinic, St. Mary's has a clinic.
21 I can't speak for them all.

22 COMMISSIONER STRACHAN: Are they staffed
23 by full or part-time personnel?

24 DR. H.T. OLIVER: Part-time personnel,
25 with the exception of the teaching hospital.

26 COMMISSIONER STRACHAN: Referring to the
27 teaching hospitals brings to mind the training of auxi-
28 liaries. Do you support training of auxiliaries?

29 DR. A.W. OLIVER: Well, Dr. Strachan,
30 it depends on what you mean by an auxiliary, and what



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COMMISSIONER STRACHAN: Are they started
by full or part-time personnel?

with the extension of the teaching hospital.
COMMISSIONER STRACHAN: Referring to the
teaching hospital brings to mind the training of dental
assistants. Do you support training of dental
assistants on what you mean by an auxiliary, and what



1 people feel an auxiliary should do. Certainly all
2 professional men want to do as much as they can; certainly
3 the way it is today the more they do, apparently the
4 more they make, but on the other hand we do feel that
5 auxiliaries are sometimes well out of hand in some
6 countries. We would like to have a little bit more
7 understood what is meant by auxiliary. If you mean by
8 an auxiliary a technician who does technical work, that
9 is fine. If you mean a technician that is now in a
10 position to set up and do the complete process from
11 taking the impression, to taking them and delivering them
12 and acting then as a dentist, no, we are not too much in
13 favour of that.

14 Then, if you mean by auxiliaries a
15 woman trained to do fillings and put fillings in then
16 we are not too happy about that at all. We feel those
17 things get out of line and there is nothing in the world
18 to stop them setting up their own offices, and we feel
19 that is not conducive to good dentistry.

20 Certainly all of the profession, this
21 puts practically a double standard on, because if you do
22 it that way, you have two-year trained personnel doing
23 what six-year trained personnel were doing. In most
24 cases that seems to me a very unfair thing to the six-year
25 personnel. If you assume...

26 COMMISSIONER STRACHAN: Is it unfair to
27 the public?

28 DR. A.W. OLIVER: Well, I am getting to
29 that, sir, I am sorry. If you assume that they are doing
30 it as well as the six-year personnel is doing, well then,



1 we have been making an awful lot of mistakes in training
2 our dentists. It would be something like saying, why
3 don't we have the nurses delivering the women at birth
4 because after all they have been doing that in Europe
5 for a long time, and certainly there is no reason why
6 they should not, or why don't we let - give a two-year
7 course to the orderlies and let them take tonsils and
8 adenoids out. After all it wouldn't be a difficult
9 thing to do. It hardly seems possible we should go into
10 that, but if you mean that type of auxiliary, no, we
11 are not for them at all.

12 If you mean an auxiliary that aids us
13 at the chair and aids us in the accounts and aids us in
14 the denture work, the mechanical denture work, yes, we
15 have always been in favour of that. The more we can get
16 the better we would like it.

17 COMMISSIONER STRACHAN: You made no
18 reference to hygienists.

19 DR. A.W. OLIVER: Pardon?

20 COMMISSIONER STRACHAN: Would you like
21 to refer to dental hygienists?

22 DR. A.W. OLIVER: The dental hygienist
23 goes to the extent only of doing the polishing of teeth
24 and certainly not filling of teeth, and that was what I
25 was making a point of. We don't want them into the
26 filling of teeth. When it comes to the polishing of
27 teeth, I think they can probably do a certain amount.
28 It is surprising how few we feel would be employed to do
29 that.

30 If they were only allowed to do that

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1 alone they would be some use, I am sure, but not nearly
2 as much as people would suppose. I don't believe that
3 the work done, the work that is to be accomplished,
4 would be as much as to be hoped for.

5 COMMISSIONER STRACHAN: Do you not feel
6 they have a place in educating the public.

7 DR. A.W. OLIVER: Yes, they certainly
8 do. There is no doubt about that at all. The thing is
9 to get them employed after you have them training, and
10 I suspect the amount that would be employed would not be
11 very high.

12 Now, in the States they always used to
13 claim they could use as many as graduated, the only
14 trouble was that all the graduates got married and they
15 weren't using as many as they thought. I believe they
16 have had second thoughts too, in the States, in some of
17 these cases.

18 COMMISSIONER STRACHAN: Whoever would
19 like to answer this: would you care to explain to the
20 Commission, not in technical terms, why in so many
21 dental procedures or operations, although nominal, they
22 vary greatly in the time consumed to accomplish them.

23 DR. CAMERON: I think one of the reasons
24 for this is that we are dealing with patients and your
25 requirements are different in each case. In non-technical
26 terms, in the field I am interested in, the patient can
27 fall into roughly three categories.

28 One situation is such that the patient
29 will require a full upper and lower denture, even if they
30 have remaining teeth. It doesn't matter what the dentist



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 2 as much as people would suppose. I don't believe that
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 24 terms, in the field I am interested in, the patient can
 25 fall into roughly three categories.

26 One situation is such that the patient
 27 will require a full upper and lower denture, even if they
 28 have remaining teeth. It doesn't matter what the denture



1 does, due to the physical condition, and perhaps neglect,
2 the remaining teeth will be lost.

3 The second case, you have a patient
4 coming to the dentist almost in time and perhaps the
5 dentist can conserve their remaining teeth.

6 The third category is where something
7 is done, treatment is prescribed for the patient and
8 properly executed; the remaining teeth can be saved for
9 a long period of time. Under those conditions it is
10 well worth taking time to do extensive work to construct
11 bridges, partial dentures, in order to save the remaining
12 teeth, so that it is, in actual fact, although they are
13 the same, the matter of each patient - they are not
14 really the same. Each patient is an individual. If we
15 want to construct dentures for models as technicians
16 would, they are constructing dentures for models, but as
17 dentists we are constructing and prescribing treatment
18 for human beings and each patient is an individual.

19 COMMISSIONER STRACHAN: Is that also not
20 true in straight operative work?

21 DR. CAMERON: Definitely, that is quite
22 true. In some cases, extensive dentistry will be
23 required and in some cases extensive dentistry is not
24 required. A tooth may require a crown, if you are
25 speaking in simple language. It may take half an hour
26 to prepare the crown, in some cases, and in other cases
27 it may take two or three visits of half an hour to
28 prepare the crown.

29 Again, that is a matter of the individual.

30 COMMISSIONER STRACHAN: Is it true that



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COMMISSIONER STRACHAN: Is it true that



1 using simple restoration, which is known by simple terms,
2 that can also vary greatly in the time necessary to
3 accomplish restoration?

4 DR. CAMERON: That is quite true. In
5 actual fact, if you are talking about drilling of teeth,
6 drilling of teeth takes in most cases very little time.
7 It is the preparation and the filling of the tooth that
8 takes the longer period of time.

9 COMMISSIONER STRACHAN: I would like to
10 refer to your statement in paragraph 32. You say:

11 "We ask for no government subsidies,
12 but we do recommend encouragement of
13 students to enter the profession
14 through the assurance that the
15 dentist will retain his rights as an
16 individual and not be regimented."

17 In this connection, the other day, and
18 I am not reading from transcripts, but I am reading from
19 a quoted sentence from a newspaper in which it was said
20 the aim of a health insurance plan is not to conserve
21 the liberty of the doctors but the liberty of the people
22 and the right to health.

23 Would you agree that regimentation of
24 a profession is not necessarily in the interest of the
25 public as well as dentists?

26 DR. CAMERON: Are you addressing your
27 question to me? I will leave it to the Chairman.

28 DR. A.W. OLIVER: I think you are
29 quite right on that. It is not put in entirely as a
30 selfish idea. We are really thinking of dentistry for

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quite right on this. It is not put in entirely as a
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1 the patients, otherwise I doubt very much if we would
2 make much of a success as a dentist today, and one of
3 the things that we are clearly aware of is we need
4 more dentists, and one of the great things that helps
5 us to get dentists today is that the man can be his own
6 boss, his own time centre. He can do his work as fast
7 or slowly and as meticulously as he so wishes. He
8 doesn't have to work on a time limit. He doesn't have
9 to work, shall we say, on a number requirement. If he
10 doesn't want to earn as much that is all right.

11 If he is on salary he is governed by
12 the fact that he has so much to earn. He is getting it
13 anyway and so is everybody else getting it anyway and
14 why should he work a different way from the other
15 fellow?

16 For while this is true you will find
17 the men will do their own work no matter what, whether
18 they are on salary or whether they are not. That goes
19 on for a while, but sooner or later, somebody points out
20 that this man is producing more than that man and we
21 are paying him the same, so what is going to happen?

22 It may be he is producing units less,
23 but he is likely doing much more meticulous work and
24 certainly work that will not have to be done over and
25 again at a later date.

26 I think there is a little tendency to
27 forget if you do volume that it doesn't necessarily
28 mean it is going to always stand up the same between
29 the different men.

30 Certainly there must be some men that

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and over and over again.

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mean it is doing to always stand up the same business
and certainly there must be some men that



1 can do better work than others, and if they find they
2 are doing it in such a fashion and they are all getting
3 paid the same, I think they are going to gravitate to
4 the lowest rather than the highest.

5 I think it is very important we ensure
6 the dentist retains his rights as an individual. If we
7 do that we feel we will get more dental students. If
8 we don't, they are not going to come.

9 COMMISSIONER STRACHAN: In other words,
10 you are suggesting under such a system the attrition
11 of personal integrity will finally set in?

12 DR. A.W. OLIVER: I can't see how it
13 can help but set in. A man can just stand so much and
14 there comes a time when no matter how decent he is
15 about it he will come to the conclusion he is being a
16 fool and that really somewhere along the line he has
17 got to change things a little bit.

18 He will probably cut it a little, but
19 he will always try to do his best, but he will certainly
20 speed it up. That is for sure. I can't see how he can
21 help it.

22 COMMISSIONER STRACHAN: Not resulting
23 in the highest standard of work?

24 DR. A.W. OLIVER: It doesn't help the
25 patient. No.

26 COMMISSIONER STRACHAN: Then what
27 recommendation would you make for the expansion of
28 dental services at the present time since the supply,
29 the limited supply of dentists is recognized?

30 DR. A.W. OLIVER: Well, we are thinking



1 can be better work than others, and if they find they
 2 are going to do such a fashion and they are all getting
 3 paid the same, I think they are going to gravitate to
 4 the lowest rather than the highest.

5 I think it is very important we change
 6 the dentist retains his rights as an individual. If we
 7 do that we feel we will get more dental student. If
 8 we don't, they are not going to come.

9 COMMISSIONER STRACHAN: In other words,
 10 you are suggesting under such a system the retention
 11 of personal integrity will finally set in?

12 DR. A.W. OLIVER: I can't see how it
 13 can help but setting. A man can just stand so much and
 14 there comes a time when the matter how decent he is
 15 about it he will come to the conclusion he is being a
 16 fool and that really somewhere along the line he has
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1 about that right now, getting a dentist to go in now.
2 We are thinking back about after the war-time when a
3 tremendous number of young fellows went in for engineering.
4 It became very, very popular, and they had very large
5 classes. In fact, it is only now they are starting to
6 drop, and, of course, we wouldn't like to think that
7 they all went in there just for the money, but one of
8 the things that certainly helped them was the fact they
9 could get in there, they could earn their own way through
10 during the summer. They weren't dependent on mother
11 and father and that does help, you know and then they
12 were always ready when they came out to start up with
13 some firm, and many firms were vying for them..

14 We felt that if dentistry becomes
15 known as being an opportunity; that you are your own
16 boss; you can do these things that the other fellow
17 can't do; there is nobody kicking you around; you can
18 make a comfortable living and you are sure of making
19 that living, then a lot more would be trying to get in
20 it.

21 Once they are in it I am sure they will
22 be good dentists. We feel a lot of chaps go into the
23 different professions without knowing at Grade 11 just
24 exactly whether they are going to be good for it or not.

25
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dpw

1 I think if we can have it fixed so that
2 more may want to come into dentistry because they feel
3 it is a good thing to be in, we will get the dentists
4 all right. It is slow, that is the unfortunate part of
5 it, it takes time.

6 COMMISSIONER STRACHAN: One more
7 question I would like to place before you; paragraph 10
8 you say:

9 "The only criterion available is
10 observation by those trained to
11 recognize what constitutes adequate
12 protection and service for the
13 patient and what does not."

14 I recall a certain hearing where we
15 were informed or it was stated, at least, by other than
16 a professional individual, that it would be possible to
17 supervise what a dentist did or what the dental profession
18 did.

19 Do you feel that even if you were
20 standing by the chair of another dentist without looking
21 into the mouth that you could be even moderately sure of
22 what he had done or was doing?

23 DR. FREDERICK: I have had a bit of
24 this experience in dealing with students and I know by
25 the way he goes about it, about his work, I have a rough
26 idea. However, as far as a graduate of long experience
27 I cannot tell what he is doing without looking.

28 COMMISSIONER STRACHAN: You do not judge
29 the situation by standing at the chair side; you look in
30 the mouth to find what has been done?

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COMMISSIONER STRAHAN: You do not judge

the situation by standing at the chair side; you look in

the mouth to find what has been done?



1 DR. FREDERICK: That is right, that is
2 the only sure way.

3 COMMISSIONER STRACHAN: And if it came
4 to a matter of judgment under a situation of appeal
5 where, with the necessary machinery set up, that work
6 cannot be observed for months after it had been done;
7 do you feel that would be adequate judgment under the
8 circumstances, of what had been done?

9 DR. FREDERICK: No, I cannot say that.
10 It would depend on the circumstances, the general nature
11 and co-operation of the patient - there are many factors.

12 COMMISSIONER STRACHAN: You cannot
13 conceive of any way that dental treatment could be super-
14 vised?

15 DR. FREDERICK: I think you would have to
16 have another dentist standing beside the one working to
17 watch and that seems like a waste and even then I doubt
18 if you would get a very accurate picture.

19 COMMISSIONER STRACHAN: I do not think I
20 have anything else at this time but there may be some-
21 thing else comes to my mind later on.

22 THE ACTING CHAIRMAN: Thank you, Dr.
23 Strachan. Dr. Van Wart, have you any questions?

24 COMMISSIONER VAN WART: You mentioned in
25 your summary E and the same statement is made at page 18
26 or page 4, Section 18:

27 "A plan under which all our observa-
28 tions confirm that the poor fare
29 better than when under a State-
30 controlled scheme."

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on page 18, Section 18:

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tion confirms that the poor fare

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1 Does that mean the poor fare better
2 both for treatment and preventive dentistry?

3 DR. H.T. OLIVER: If I may answer that.
4 It certainly refers to treatment. Now, as to preventive
5 dentistry, we do not care particularly who inaugurates
6 the preventive dentistry. From the point of view of the
7 basic recommendations as to fluoridation and so forth
8 and education of the patient this means nothing except
9 that the dentist would be doing research and so forth.

10 As to the treatment we certainly believe
11 that they would be, on the long-term project, they would
12 be worse off than they are now.

13 COMMISSIONER VAN WART: Do you mean
14 that under your plan treatment is more available to the
15 poor than it would be under a State-controlled plan?

16 DR. H.T. OLIVER: No, I say again on
17 the short-term, that is the point, we can just look
18 after so many people because we have just so many bodies
19 and so many dentists to provide this treatment. Now,
20 if we do not care particularly who receives this treatment
21 as such but if you take dentists from one group and
22 provide another group with the dentistry, in this case
23 the poor people, the indigents who, goodness knows we
24 are all striving and doing our best to do what we can
25 there; what is left over after having looked after the
26 former group but if you take the dentists away from the
27 group who are at present paying for the dentistry and
28 you put them to work on those who are not paying for
29 the dentistry, as such, it is not long before the group
30 who are now in Canada who do without dentistry to provide

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the dentistry, as such, it is not long before the group
who are now in Canada who do without dentistry to provide



1 funds to look after it completely.

2 How is it they cannot have dentistry;
3 we are the scapegoats, somebody else has made the
4 promise of dentistry for all and it is humanly impossible
5 to do it.

6 To justify the promise they either have
7 to turn out more dentists, which we are in favour of,
8 or have personnel poorly trained and the cycle starts
9 and you have poorly trained personnel standing in a
10 white coat beside a chair. It is hard to judge what the
11 public are getting and you have lowered your standard of
12 dentistry and cut off the incentive for men to enter
13 into the profession of dentistry itself.

14 COMMISSIONER VAN WART: If I understand
15 you, under the present system those who can afford their
16 dentistry get their dentistry with a priority over those
17 who cannot afford it?

18 DR. H.T. OLIVER: That is absolutely
19 correct.

20 COMMISSIONER VAN WART: Therefore, the
21 poor are getting better service, that is what you say?

22 DR. H.T. OLIVER: We say in the long
23 run we are doing our best to look after the poor but we
24 do our best with X number of dentists. We would like to
25 look after everybody, we would like the demand for our
26 services to be such that we would graduate more dentists
27 and look after everyone but we cannot look after everyone.

28 What we have left over in the way of time
29 and effort we are gladly donating to the pool, first
30 class dentistry, but we do not condone the lowering of



1 the dental standards because in the long term the
2 profession will suffer which means our patients and
3 the public in general will suffer.

4 COMMISSIONER VAN WART: You are saying
5 that the shortage of dentists is an acute problem in the
6 treatment of the poor?

7 DR. H.T. OLIVER: Yes.

8 COMMISSIONER VAN WART: Do you believe
9 with the present scheme you have well-trained, more
10 dentists than a State-controlled scheme will train?

11 DR. H.T. OLIVER: Yes, I believe so.
12 You must remember that this is linked up with the
13 question of demand for these people who want dentistry.
14 It is not necessarily socio-economic in its base, We
15 know college professors who neglect their teeth and we
16 know scrub women who are glad to do anything they can
17 to have their children's teeth attended to. It is not
18 actually socio-economic in this sense, it is the demand.

19 COMMISSIONER VAN WART: I realize that
20 many people will not go to a dentist until they have a
21 pain or some other condition will drive them to a dentist
22 but I still cannot see how the poor are going to fare
23 better under the present scheme which is in operation
24 than under a State-controlled scheme which presumes you
25 are going to train more dentists because more money will
26 be available to train these dentists, that services will
27 be more available to the poor than it is at the present
28 time.

29 You have not made yourself clear to me
30 on that statement as yet.

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12 You must remember that this is linked up with the
13 question of demand for these people who want dentistry.
14 It is not necessarily socio-economic in the sense. We
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16 know school women who are afraid to do anything they can
17 to have their children's teeth attended to. It is not
18 socially socio-economic in this sense, it is the demand.
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20 many people will not go to a dentist until they have a
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27 be more available to the poor than it is at the present

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30 in that statement as yet.



1 DR. H.T. OLIVER: As to the State-
2 controlled training of dentists, our experience and
3 observations of other countries, this just does not
4 work out, you just do not get first-class applicants
5 to go into dentistry. I believe England is one case
6 in point where once you have a State-controlled scheme
7 the applicants drop in that particular phase of it.

8 COMMISSIONER VAN WART: Is dentistry
9 better today in England than it was before the scheme
10 came on among the poor?

11 DR. H.T. OLIVER: If I can digress a
12 bit here; in England they have set up a scheme where
13 everybody had to get dentistry. Well, just as I
14 mentioned, after a while this worked fine for a short
15 time with the sudden demand because it was then found
16 that those taxpayers who were wanting to have their
17 dentistry done who formerly had their dentistry done
18 were now doing without dentistry and waiting their turn
19 in line.

20 In this case they would then go to the
21 dentist and this pretty well sent the dentist back into
22 private practice and just part-time in the other. In
23 some cases they found they had to charge the poor people
24 some basic fee, a very small fee, for their dentures and
25 so forth. Costs of the scheme are so great the personnel
26 of dentists was lowered. From the point of view of admini-
27 strators you had to take dentists away from the profes-
28 sion and make them administrators and thereby losing
29 more production and the vicious circle started once again.

30 COMMISSIONER VAN WART: What you are



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some cases they found they had to change the law people

some basic law, a very small fee, for their dentures and

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of dentists was increased. From the point of view of adminis-

tration you had to take dentists away from the profes-

sion and make them administrators and thereby losing

more production and the various circle started some more

COMMISSIONER VAN WART: When you



1 saying is that those who were receiving good dentistry
2 before the plan came into effect are getting poor
3 dentistry now but the poor are getting better dentistry;
4 that is what I take from your statement.

5 DR. H.T. OLIVER: I think you have
6 reached the stage in England now where the poor are now
7 getting short appointments and so on and so forth; they
8 are not getting good dentistry, in fact, dentistry as a
9 whole, the standard has dropped immensely. I think it
10 is quite a mess over there and we would not like to see
11 that happen to the Canadians.

12 COMMISSIONER VAN WART: We are talking
13 about the poor.

14 DR. H.T. OLIVER: To the poor Canadians.
15 Mind you, we want to help the poor, do not misinterpret
16 me.

17 COMMISSIONER VAN WART: I am not saying
18 you do not give service.

19 DR. H.T. OLIVER: We seek to do that
20 but in the long term where they are graduating more
21 dentists the poor will have a much better chance of
22 receiving better dentistry.

23 COMMISSIONER VAN WART: It was just the
24 statement you made categorically that the poor are
25 faring better now than they would under a controlled
26 plan; that is what I wanted to elaborate on and get
27 your viewpoint on, that you come to that conclusion.
28 You have not convinced me as yet. That is all.

29 COMMISSIONER BALTZAN: Gentlemen, the
30 name of your group intrigues me very much; the Montreal



1 Dental Club. You have 214 members, how do these people
2 become members of your Club; is there any exclusion or
3 certain requisites for admission to your Club and who
4 do they represent?

5 DR. FREDERICK: They represent graduates
6 of McGill University for the most part; well over 95%,
7 I would imagine are recent graduates of McGill.

8 COMMISSIONER BALTZAN: And those who
9 apply may then become members of the Club?

10 DR. FREDERICK: The ones who apply.

11 COMMISSIONER BALTZAN: And it is
12 confined to members of McGill University?

13 DR. FREDERICK: No, a person may come
14 from another city and apply for membership.

15 COMMISSIONER BALTZAN: And not necessarily
16 a graduate of McGill University?

17 DR. FREDERICK: Oh, no.

18 COMMISSIONER BALTZAN: Do you have
19 others besides the graduates of McGill and the people
20 you have mentioned belonging to your Club from other
21 dental schools in the province or the city?

22 DR. FREDERICK: At the moment I cannot
23 answer that offhand. There are very few. It just so
24 happens that we have three societies in Montreal, the
25 Mount Royal, the Dental Association and the Montreal
26 Dental Club and we each gravitate to the one that
27 interests us.

28 COMMISSIONER BALTZAN: And your activities
29 are confined to scientific and perhaps social?

30 DR. FREDERICK: Not very much social.



1 We have meetings every month and a convention every year
2 with programs of scientific interest.

3 COMMISSIONER BALTZAN: Looking at your
4 summary, on the first page, the alphabetical order of
5 things; you have stated, I see the word "plan" mentioned
6 six times out of eight. You can correct me if I am
7 wrong or if I am right but I do not see where you state
8 a plan. I do not seem to get in your declarations from
9 (a) to (h) anything new. Do you not have most of these
10 things that you state on page 1?

11 DR. FREDERICK: Yes, that is the plan,
12 the conditions under which we are operating now that we
13 believe are in the interests of the best type of
14 dentistry for the most people by keeping the standard
15 of the profession high and we believe everyone will
16 thus benefit.

17 COMMISSIONER BALTZAN: You are advocating
18 preservation of the status quo with certain modifications
19 and wish to preserve this system; that is your plan?

20 DR. FREDERICK: Our plan is the preser-
21 vation of the practice of dentistry under conditions of
22 free enterprise with, as we have stated, the additional
23 stimulus of recruiting and public enlightenment in what
24 they can do for the best public education in the region
25 of oral health and naturally in the promotion of a public
26 body for fluoridation of the water supply which, as you
27 are aware, I am sure, in one stroke would reduce the
28 dental disease by about 50%.

29 COMMISSIONER BALTZAN: Dr. Van Wart
30 covered a lot of things I had in mind and there was a



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1 lot of questions I had on the treatment of the poor and
2 I cannot bother with this because you explained it in
3 your own way.

4 I want to ask one simple question; under
5 the existing circumstances is it known generally that a
6 patient in need of dental care, who belongs to the class
7 that is called poor, we do not hear that word too often,
8 is such a person turned away because he has not got the
9 means?

10 DR. FREDERICK: This is not so, Doctor.

11 COMMISSIONER BALTZAN: On page 2, and
12 again I see it on page 4, page 2, six is the paragraph,
13 again a matter of principle, but it seems to be like a
14 guiding statement:

15 "How can you expect a man to work at
16 his best when he knows that others
17 will receive as much financially
18 for very indifferent type of work."

19 On page 4, the top paragraph, the
20 last two lines:

21 "Why then should not the dentist
22 work for the price rather than to
23 perfection?"

24 Is that basically your objection to a
25 State system of the practice of dentistry?

26 DR. A.W. OLIVER: Yes, I would say that
27 that was basically our objection. We feel that we want
28 to have dentistry stay at a high level.

29 COMMISSIONER BALTZAN: And that could
30 only be done on the basis of the individual relationship,

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DR. PRITCHARD: This is not so, I think.

COMMISSIONER ELLIOTT: On page 2, and

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only be done on the basis of the individual relationship.



1 both professionally and economically, with the source
2 of his remuneration?

3 DR. A.W. OLIVER: Yes, I think so.

4 COMMISSIONER BALTZAN: Lastly, on page
5 5, paragraph 23 has been, in part, answered, but:

6 "In Great Britain and New Zealand"
7 you state your conditions there, and my question is:
8 have the numbers of graduates in dentistry been on the
9 decrease since the introduction of National Health?

10 DR. A.W. OLIVER: Yes, that is true.
11 They are down, and there is, of course, I guess there is
12 a rise in the number of dental auxiliaries, but the
13 dentists themselves are falling in numbers. That is
14 quite right, and they are almost worried lest there
15 come a time when dentistry becomes entirely auxiliary.

16 COMMISSIONER BALTZAN: Why do you think
17 that has been so; what is the cause?

18 DR. A.W. OLIVER: Well, you see, no
19 child in New Zealand has dentistry performed by anyone
20 but an auxiliary until 14 years of age.

21 COMMISSIONER BALTZAN: Even if major
22 work is required on that child?

23 DR. A.W. OLIVER: As far as I know,
24 well, I don't mean by that perhaps the removal of cysts,
25 and things like that. That is quite true, but I am
26 referring to operative dentistry; the child goes to the
27 school and the school does the work there, so conse-
28 quently, outside of a few references, that is true.

29 COMMISSIONER BALTZAN: And in these
30 same countries having specific systems has the quality



1 of dental services declined?

2 DR. A.W. OLIVER: Yes, we feel that it
3 has declined. Now, when you get a person trained to
4 do the set things, such as fillings, yes, there is no
5 reason why you couldn't train anybody to do a certain
6 type of filling, but that does not necessarily mean
7 that they are going to be giving good overall dentistry,
8 and we feel that it has slipped quite badly, for the
9 simple reason that the auxiliary can handle just that
10 and not much more and it does cut down on the desire
11 of good students to go into dentistry.

12 Numbers even don't help. You like to
13 feel that you have a profession that has sharp people
14 in it, not just numbers. That does not produce the
15 best in any profession. If you have medical students
16 that have been failing in their coming up to medicine,
17 well, they don't want them because they feel that they
18 won't make good doctors and we feel the same in dentistry.

19 COMMISSIONER BALTZAN: Under this system,
20 confining ourselves to the qualified graduate dentist in
21 his daily work, has his work, his services, the quality
22 and standard declined? I am not talking about the
23 auxiliaries.

24 DR. A.W. OLIVER: That, of course, is
25 a very difficult thing to answer because it is pretty
26 hard to prove one way or another, isn't it? I think
27 where it is suffering is this: that the man that is
28 left is getting pretty inadequate.

29 COMMISSIONER BALTZAN: Therefore his
30 quality, his production, is impaired. I am not putting



1 words in your mouth.

2 DR. A.W. OLIVER: Yes, that is the
3 feeling I got from talking to the New Zealanders, that
4 they definitely were browned off, and if you get that
5 way the quality does suffer. It is pretty hard to
6 put your finger on it, but I do think that is true.

7 COMMISSIONER BALTZAN: That is your
8 belief?

9 DR. A.W. OLIVER: That is my belief.

10 COMMISSIONER FIRESTONE: Mr. Chairman,
11 I am addressing my questions to Dr. Frederick, but
12 please feel free to call on your colleagues.

13 As I understand, sir, the proposal of
14 your group is that you recommend the continuation of
15 the existing system, and that is the practice of
16 dentistry under a free enterprise system, and that the
17 two basic changes that you would like to see are, one,
18 increased preventive dental health services, including
19 fluoridation; and secondly, measures taken to increase
20 the supply of dentists. Am I correct in that understand-
21 ing?

22 DR. FREDERICK: Yes sir.

23 COMMISSIONER FIRESTONE: Now sir,
24 assuming that these two recommendations of yours are
25 implemented, the problem will still remain of how to
26 provide increased dental services to people that cannot
27 afford to pay for such dental services, whom, for these
28 discussions' sake, we will describe as the indigents.

29 As I understood, sir, you were suggesting
30 that the indigents at the present are looked after in two



1 manners. One by the dentist who will look after some
2 people for the limit of the time available free of
3 charge?

4 DR. FREDERICK: Yes.

5 COMMISSIONER FIRESTONE: And secondly
6 through people going to dental clinics. Am I correct
7 in that understanding?

8 DR. FREDERICK: Yes sir.

9 COMMISSIONER FIRESTONE: Therefore,
10 the first method of presently providing dental service
11 to the indigent depends on the charity of a dentist;
12 am I correct?

13 DR. FREDERICK: Partly, I believe.

14 COMMISSIONER FIRESTONE: And therefore
15 the dentist is really subsidizing people who cannot
16 afford to pay for such dental services?

17 DR. FREDERICK: We feel it is, well, a
18 contribution we can give to the community.

19 COMMISSIONER FIRESTONE: Well, this is
20 a very laudable practice, and I think you are to be
21 congratulated for providing the service, but in fact,
22 the dental profession subsidizes the indigent, rather
23 than the community as a whole; is that so?

24 DR. FREDERICK: Well, I don't believe
25 that is so entirely. There are clinics that are supported
26 by social service monies.

27 COMMISSIONER FIRESTONE: I am coming
28 back to the clinics in a moment.

29 I am talking about the case where the
30 patient comes to the dentist and says: "I am sorry, I



1 cannot pay you" and the dentist says: "All right, I
2 have 15 minutes, I will look after you." Would you say
3 that in these cases the dentists are subsidizing dental
4 services out of their own good nature?

5 DR. FREDERICK: I don't think so
6 entirely. They will go to an organized clinic.

7 COMMISSIONER FIRESTONE: In other words,
8 dentists would not provide these services, but service
9 to a dental clinic?

10 DR. FREDERICK: I think he would be
11 more likely to get his attention in that manner, rather
12 than in a man's office. It could happen occasionally.

13 COMMISSIONER FIRESTONE: Therefore,
14 the bulk of the indigents are taken care of in dental
15 clinics?

16 DR. FREDERICK: I would think so.

17 COMMISSIONER FIRESTONE: Well now, sir,
18 when an indigent comes to a dental clinic and he
19 complains about severe pain, he is seen by a dentist?

20 DR. FREDERICK: Yes.

21 COMMISSIONER FIRESTONE: The dentist
22 then diagnoses that he requires treatment, but not
23 pulling a tooth. What would the dentist do?

24 DR. FREDERICK: Well, in most cases
25 I believe the man would be assigned. The patient would
26 be assigned to someone in that clinic to help him.

27 COMMISSIONER FIRESTONE: He would
28 receive the treatment, even though it may require treat-
29 ment over an extended period of time, without the neces-
30 sity of pulling a tooth?



1 DR. FREDERICK: Well, assuming that is
2 the best way to handle it, yes.

3 COMMISSIONER FIRESTONE: Therefore,
4 dentistry is not just handled by pulling teeth in the
5 dental clinic?

6 DR. FREDERICK: No, not in Canada.

7 COMMISSIONER FIRESTONE: Not in your
8 clinics?

9 DR. FREDERICK: No.

10 COMMISSIONER FIRESTONE: We have heard
11 different stories in other provinces. That is why I
12 want a specific answer for dental clinics in Montreal.

13 DR. FREDERICK: In most cases where a
14 patient comes in in pain to ask for help it usually
15 exists, it is too late.

16 COMMISSIONER FIRESTONE: When a dentist
17 feels in good conscience he can save the tooth, he
18 wouldn't pull it, he would prescribe treatment?

19 DR. FREDERICK: I hope so.

20 COMMISSIONER FIRESTONE: There is
21 nothing in the regulations that require patients to be
22 treated, rather than have the tooth just pulled?

23 DR. FREDERICK: Not to my knowledge.

24 COMMISSIONER FIRESTONE: Perhaps some
25 of your colleagues have other knowledge on the subject?

26 DR. CAMERON: I think that most of us
27 at the moment are contributing time at the various
28 teaching clinics where they are treating indigents, and
29 as far as being paid for our services, it is very nominal,
30 and it costs us money to go there.



1 COMMISSIONER FIRESTONE: Now sir, did
2 I understand from a remark that was made earlier that
3 the limited dental services available at a clinic make
4 it impossible to look after all the indigents that need
5 dental services?

6 DR. H.T. OLIVER: Yes, I made that
7 remark, sir. It is impossible to look after the needs.
8 It is not always impossible to look after the demand
9 for dental services required.

10 COMMISSIONER FIRESTONE: Could you
11 explain this a little sir? If the number of people
12 coming to the dental clinic; are these people looked
13 after, or do you have an insufficient number of dentists
14 to look after them?

15 DR. H.T. OLIVER: I would say from the
16 experience that we have had at the hospital, that not
17 only do we look after them, but in many instances they
18 do not return for the future appointments which we
19 gladly provide for them, and I am not remiss in saying
20 that on occasion we have gone down and sat idle, which
21 aggravates us no end.

22 COMMISSIONER FIRESTONE: What is the
23 problem, sir? Is it that the indigents do not require
24 dental services, or that they are not interested in
25 coming to the clinic, or that they do not want to be
26 treated as charity patients? There must be a reason
27 when dentists sit there and there are no patients, when
28 we know that the need is so great.

29 DR. H.T. OLIVER: I don't think the
30 charity part bothers them so much, but it is almost a



1 question of, and here again, as I say, it is not solely
2 economics, this can apply to any walk of life. They
3 come primarily when they are in pain. In many
4 instances we try to encourage them not to neglect their
5 teeth further, and go to a great deal of trouble with
6 patient education to do that, but often we do not see
7 them until they have pain again.

8 However, if we could educate these
9 people, perhaps in the schools and by other means, at
10 the public's availability now, I am sure it is a
11 question of changing public opinion.

12 If we could get these people to follow
13 certain procedures which we have been advocating for
14 a great time, and it worries us no end to see small
15 children with these enormous cavities and aching teeth,
16 and having them ripped out when it could be prevented,
17 but it is not a popular measure to take them off sweets
18 and other things.

19 COMMISSIONER FIRESTONE: Do you have,
20 in the City of Montreal, arrangements whereby children
21 are examined, as far as their dental health is concerned,
22 in school?

23 DR. FREDERICK: Yes, we do have that.

24 COMMISSIONER FIRESTONE: And what
25 happens when cavities are detected?

26 DR. FREDERICK: Well, in the first
27 place, of course, we have to remember that this is a
28 cursory examination.

29 COMMISSIONER FIRESTONE: Done by whom,
30 sir?



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COMMISSIONER FIRESTONE: Do you have, in the City of Montreal, arrangements whereby children are examined, as far as their dental health is concerned, in schools?

DR. FREDERICK: Yes, we do have that.

COMMISSIONER FIRESTONE: And what

proceeds when cavities are detected?

DR. FREDERICK: Well, in the first

place, of course, we have to remember that this is a curative examination.

COMMISSIONER FIRESTONE: Done by whom,



1 DR. FREDERICK: Done by a dentist.
2 He will examine that child in the school clinic and
3 observe any manner of pathology which might appear as
4 far as cavities, but it is still a cursory examination
5 as compared to what he would perform in his office.

6 Then he fills out a card which goes to
7 the parents, asking them to report to the dentist. If
8 the parents wish to have that work done, all well and
9 good. Otherwise it is their prerogative, as in any
10 free country. It is a free choice.

11 COMMISSIONER FIRESTONE: Who appoints
12 those dentists?

13 DR. FREDERICK: I believe most of us
14 volunteer for this position.

15 COMMISSIONER FIRESTONE: Is it the
16 Department of Education, or the Protestant School Board,
17 or any school board?

18 DR. FREDERICK: I believe it is the
19 school board.

20 DR. H.T. OLIVER: And the Red Cross.
21 No, just the school boards.

22 COMMISSIONER FIRESTONE: Would you feel
23 that more could be done if more time could be devoted to
24 a more careful examination, or would you feel that the
25 problem is the follow-up? What is wrong with the
26 existing system that gives us children with the sort of
27 dental health which you have described? What can be
28 done to cope with the problem?

29 DR. H.T. OLIVER: Well, firstly I
30 would say, let us not let it happen.



MR. BRONSTEIN: I am by a dentist.

I will examine that child in two or three days and

report any matter of pathology which might appear as

far as cost goes, but it is still a costly examination

as compared to what he would perform in his office.

Then he finds out a good many more to

the parents, asking them to report to the dentist. If

the parents wish to have that work done, all well and

good. Otherwise it is their prerogative, as in any

free country. It is a free choice.

COMMISSIONER BRONSTEIN: Who examines

those dentists?

MR. BRONSTEIN: I believe most of us

COMMISSIONER BRONSTEIN: Is it the

Department of Education, or the Department of Health?

or any other body?

MR. BRONSTEIN: I believe it is the

the local school boards.

COMMISSIONER BRONSTEIN: Would you feel

that more could be done if more time could be devoted to

a more careful examination, or would you feel that the

problem is the policy and that is wrong with the

existing system, and given no conflict with the

general health which you have mentioned. What can be

done to cope with the problem?

MR. BRONSTEIN: I do not feel it necessary.



1 COMMISSIONER FIRESTONE: And the next
2 stage?

3 DR. H.T. OLIVER: Now that it has
4 happened, well, let's get on the job and look after them.
5 That is what we are doing to the best of our ability,
6 and we want dentists to do that.

7 COMMISSIONER FIRESTONE: Were you not
8 saying that one of the difficulties is that you cannot
9 give an adequate examination?

10 DR. H.T. OLIVER: That is quite true.
11 We don't give an adequate examination in our schools
12 as such.

13 COMMISSIONER FIRESTONE: How could
14 this be achieved? Would the employment of dental auxi-
15 liaries, together with dentists, make it possible to
16 give a more adequate service?

17 DR. H.T. OLIVER: No, I think it is a
18 question that he must have adequate equipment to do this.
19 He is asked to see the school by class, and it is a
20 physical impossibility to give them a thorough examination.

21 COMMISSIONER FIRESTONE: Have you any
22 suggestions how the present system, which you have
23 yourself described as inadequate, could be improved?

24 DR. H.T. OLIVER: Well, basically you
25 have already accepted our tenet of prevention, the
26 treatment as such. Many of us prefer to work on children.
27 Others, for various reasons, you cannot --- to treat a
28 child, which I would prefer to see the children treated
29 first, but many men are not suited, they do not choose
30 to work on children, through no fault of their own.



1 Each child is an individual and many
2 of them do not even go to bed when told by their parents.

3 COMMISSIONER FIRESTONE: But what can
4 be done? Do you want more dentists to be trained that
5 will take care of children?

6 DR. H.T. OLIVER: Yes, produce more
7 dentists.

8 COMMISSIONER FIRESTONE: Supposing
9 there could be an encouragement offered to induce more
10 students to enter dentistry, how would you do it?
11 Scholarships, fellowships or other ways?

12 DR. H.T. OLIVER: Yes, I believe so.
13 I believe it is always an encouragement for a chap where
14 he does not have an opportunity in our particular line
15 of work to earn sufficient in the summer to cover his
16 fees, but I don't know anyone in our universities who
17 has been turned down for lack of money. Our problem is
18 to get the student to choose the profession.

19 COMMISSIONER FIRESTONE: We are coming
20 to you for advice. We agree you need more dentists.
21 How can this be achieved?

22 DR. H.T. OLIVER: One way is to stop
23 the worry that they are going to be regimented. If
24 they can be reassured that they are not going to be under
25 a plan would in itself increase the amount of enrolment
26 enormously.

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of them do not even go to bed when told by their parents

COMMISSIONER FIRSTONE: But what can

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to you for advice. We agree you need more dentists.

How can this be solved?

DR. H.T. OLIVER: One way is to stop

the way that they are going to be recruited. If

they can be recruited that they are not going to be under

a high level in their interest the amount of enrollment



1 COMMISSIONER FIRESTONE: Doctor, we
2 have had a system where they were without regimentation
3 for 100 years in Canada and we are still short of
4 dentists. You want to wait another 100 years?

5 DR. H.T. OLIVER: They are not making
6 it appealing enough as such, perhaps, to make them
7 enter the profession of dentistry. When they can
8 graduate after three years or four years of college,
9 enter another profession, equal, as far as society is
10 concerned, it seems not very strange they would elect
11 to go into them rather than four years of dentistry.

12 COMMISSIONER FIRESTONE: Doctor, can
13 you propose something concrete that would encourage
14 young students to go into the field of dentistry?

15 DR. H.T. OLIVER: I would suggest that
16 you give them financial assistance in the manner of
17 writing off the cost of their education as a capital
18 expenditure; either the student, the parents or
19 the person who is sponsoring them.

20 There are many people who are glad to
21 sponsor individuals to go through for dentistry and
22 medicine if they can get some tax relief of this sort.
23 They would rather deal with human beings.

24 COMMISSIONER FIRESTONE: This is one
25 concrete suggestion. Have you any other suggestions?
26 Do you feel the one suggestion would bring an adequate
27 number of people into the field of dentistry?

28 DR. H.T. OLIVER: I think that could
29 be supplied by bursaries. Scholarships, of course, are
30 available. Bursaries are already available. Some are



1 not made use of. To refer again to your statement, it
2 is quite true, we have to entice them in. We are
3 racking our brains right now to get students in. We
4 are in competition with every profession in this.

5 COMMISSIONER FIRESTONE: Dr. Oliver,
6 I don't want to pursue this point too far. You appre-
7 ciate it would help this Commission a great deal if we
8 had a concrete proposal of how to entice young men into
9 the dental profession. If your Association has any
10 further views on it upon further consideration we would
11 appreciate it if we could have the suggestions in
12 concrete terms.

13 If you have a taxation proposal then
14 please say what it should be. If you have a proposal
15 for additional scholarships, say how much they should
16 be and how many.

17 If you have a proposal for a different
18 type of enticement, please say so, but be concrete,
19 because if we are to come forward with a proposal to
20 the Government we would like your views. We can get
21 that from the dental profession. You know more than
22 six members of the Commission.

23 One, of course, is an expert in the
24 field. Thank you very much. Is that acceptable?

25 DR. H.T. OLIVER: Certainly.

26 COMMISSIONER FIRESTONE: Thank you.

27 THE ACTING CHAIRMAN: Thank you very
28 much, Dr. Frederick and gentlemen. Have any of your
29 colleagues anything they would like to add?

30 DR. FREDERICK: I think not, Mr. Chairman.



1 THE ACTING CHAIRMAN: Dr. Strachan?

2 COMMISSIONER STRACHAN: Mr. Chairman,
3 with reference to the question which Dr. Baltzan asked
4 regarding membership in the Montreal Dental Club, do
5 I understand correctly that you are not essentially an
6 exclusive Club?

7 DR. FREDERICK: I think the expression
8 "Club" was something inherited from 1897.

9 COMMISSIONER STRACHAN: It is rather a
10 misnomer.

11 DR. FREDERICK: It is, in fact, a
12 scientific society.

13 COMMISSIONER STRACHAN: There are no
14 membership exclusions as such?

15 DR. FREDERICK: As such, to my knowledge,
16 none have applied.

17 COMMISSIONER STRACHAN: While you have
18 an English-speaking group and a French-speaking group,
19 there are members of a French group who belong to your
20 Association?

21 DR. FREDERICK: There are French-speaking
22 members but, I said in all cases they are men who went to
23 McGill.

24 COMMISSIONER STRACHAN: McGill is not
25 essential?

26 DR. FREDERICK: No.

27 COMMISSIONER STRACHAN: Thank you, Mr.
28 Chairman.

29 THE ACTING CHAIRMAN: Thank you, Dr.
30 Frederick. Does anyone have anything they would like to



1 add?

2 DR.FREDERICK: I think not, Mr. Chairman.

3 May I thank you.

4 THE ACTING CHAIRMAN: We appreciate
5 very much your being here and the assistance you have
6 given us. I hope among us we can devise some way to
7 make people like to go to the dentist. That is very
8 important.

9 DR. FREDERICK: Thank you, Mr. Chairman
10 for receiving us.

11 THE ACTING CHAIRMAN: We will arise now
12 until 2.15.

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14 --- Luncheon adjournment.

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1 --- On resuming at 2.15 p.m.

2 THE ACTING CHAIRMAN: We will now come
3 to order. The next submission is that of La Société
4 dentaire de Montréal. Dr. Vachon, would you introduce
5 your associates and then proceed to deal with the
6 summary and recommendations contained in your brief.

7 SUBMISSION OF LA SOCIÉTÉ DENTAIRE DE

8 M O N T R É A L.

9 (Exhibit No.213)

10 Appearances: Dr. Thibeault
11 Dr. Vachon
12 Dr. Lussier
13 Dr. Bouillon
14 Dr. Gregoire
15 Dr. Guimond
16 Dr. deMontigny

17 DR. VACHON: Mr. Chairman, ladies and
18 gentlemen; on my right, Dr. Thibeault, a member of the
19 Committee of La Société dentaire de Montréal and Dr.
20 deMontigny.

21 On my right, Dr. Lussier, Dr. Bouillon,
22 and Dr. Guimond.

23 I will read you the preamble including
24 the recommendations of our brief.

25 First, compulsory fluoridation of water
26 and aqueducts by government grants. Topical application
27 of fluoride by auxiliary personnel; increase in the number
28 of dentists through scholarships and awards;
29 opposition to the immediate establishment of
30 another dental faculty, dental school, in the Province
of Quebec; establishment of schools of dental hygiene
in the existing dental schools; grants by the State to
the problem of auxiliary personnel and amendments to the
income tax act to allow deduction of expenses incurred
by dentists in post-graduate study; increase and expansion



1 of dental hygiene courses in the schools of hygiene and
2 the schools of medicine; organization of dental services
3 in hospitals; organization of a national dental health
4 insurance system under certain conditions; increase in
5 grants for dental research, and, finally, organization
6 of sustained campaigns in dental education.

7 If I may, Mr. Chairman, I will present
8 the preamble. La Société dentaire de Montréal is an
9 organization whose principal objective is a program of
10 scientific training of members by conferences, clinics
11 and conventions.

12 This Society is free. That is to say
13 its members take part voluntarily in its activities and
14 pay an annual contribution. Its members together compose an
15 element of the dental profession in Montreal and its
16 surrounding districts.

17 La Société dentaire de Montréal consti-
18 tutes the largest French-speaking scientific group in
19 Canada and it has 300 active and associate members. It
20 has close ties with the School of Dental Surgery of the
21 University of Montreal in which most of its members
22 completed their professional studies.

23 The Society is actively interested in
24 the improvement of the dental health of the population
25 of metropolitan Canada, and takes the opportunity of
26 the Royal Commission on Health Services to put forward
27 some ideas which may be of use in providing our country
28 with better dental health, so that I think the main
29 idea of our brief is an improvement, to the greatest
30 extent possible, of oral health of the population. That



1 is why we have suggested certain - we have noted certain
2 things here.

3 THE ACTING CHAIRMAN: Thank you, Dr.
4 Vachon. Is there anything else you or any of your
5 associates would like to add at the moment in elaboration
6 on all the recommendations you have made?

7 DR. VACHON: No, I think not, sir.

8 THE ACTING CHAIRMAN: Thank you very
9 much. Dr. Vachon, your first recommendation is one we
10 have heard uniformly from all the dental groups that
11 have come before us, and that is, steps should be taken
12 to either encourage or compel the fluoridation of
13 communal water supplies. What is the situation in the
14 Province of Quebec in that regard? What is the law?

15 DR. BOUILLON: As far as the law is
16 concerned there is no objection to application of
17 fluorides at the level of the various municipalities.

18 Now, as regards its application in
19 Montreal or in the areas of Montreal, the municipal
20 health service has recommended after very protracted
21 study in 1953 following a report submitted to the
22 Commission of Hygiene, approved by the Executive, as I
23 say, the health service in Montreal has recommended
24 fluoridation as have the majority of other services
25 everywhere else.

26 Fluoridation in the Montreal districts
27 at this stage is a matter for the various municipalities
28 which serve the city itself. We feel if new municipalities
29 come up at an early stage we will be surrounded by 17
30 municipalities which will be fluoridated.



is why we have suggested certain - we have not suggested

THE ACTING CHAIRMAN: Thank you, Sir.

Thank you, Sir. There is nothing else you or any of your

associates would like to add at the moment in discussion

on all the recommendations you have made?

DR. VAGBO: No, I think not, Sir.

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concerned there is no question to application of

timelines at the level of the various municipalities.

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Montreal or in the area of Montreal, the municipal

health services has recommended after very extensive

study in 1955 following a report submitted to the

Commission on Hygiene, approved by the Minister, as I

recall, the health services in Montreal has recommended

that the law be made the making of other services

everywhere else.

Discussion in the Council of Ministers

at this stage is a matter for the various municipalities

which are the City itself. We have to now make legal

some use of the City of Montreal as well as surrounded by it

and others which will be the situation.



1 As regards health authorities, I think
2 the Minister of Health, as well as governmental authorities,
3 have no objection whatsoever to fluoridation, the more
4 so as fluoridation has been recognized for many years
5 after very considerable research carried out, particu-
6 larly by the National Research Institute and in the
7 United States, demonstrating that fluoridation reduces
8 by two-thirds incidental caries. ^{W. H. V.}

9 In view of the predominance, the great
10 predominance of dental problems, particularly as regards
11 decay, I think that preventive methods constitute a
12 measure of public health such as fluoridation of water
13 supplies, should be considered as a first priority.

14 THE ACTING CHAIRMAN: Dr. Vachon, is
15 any municipality, am I right in this, any municipality
16 in the Province of Quebec is free if the governing
17 authority, the Council, decides to do so, to fluoridate
18 the communal water supply? There is no referendum
19 necessary?

20 DR. BOUILLON: No, not in the Province
21 of Quebec as far as I know.

22 THE ACTING CHAIRMAN: What proportion
23 of the water supply, communal water supply in the
24 Province of Quebec, would you say was artificially
25 fluoridated today?

26 DR. BOUILLON: Well, the proportion
27 of waters that are fluoridated today, we have no set
28 dimensions on this, where fluoridation is found naturally,
29 and naturally at one point there are - I believe, in
30 the Province of Quebec, 17 are, 17 municipalities are



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the Ministry of Health, as well as governmental authorities have no objection whatever to this position. The fact so an investigation has been recognized for many years by the Ministry of Health, and in the United States, demonstrating that this position reduces by two-thirds the number of cases.

In view of the predominance, the great predominance of dental problems, particularly as regards decay, I think that preventive methods constitute a measure of public health such as fluoridation of water supplies, should be considered as a first priority.

THE ACTING CHAIRMAN: Dr. Vanden, in any kind of way, as I might in this, any way, in the Ministry of Health in fact in the government, as the Council, decides to do so, to fluoridate the water supply, there is no objection.

Dr. BOTTING: No, not in the Ministry of Health as far as I know.

of the water supply, certainly water supply in the Ministry of Health, would you say the Ministry of Health is the only one?

Dr. BOTTING: Yes, the Ministry of Health, that are mentioned today, we have no objection on this, where fluoridation is being carried out, and actually at one point there was I believe, in the Ministry of Health, by way of a memorandum &



1 actually fluoridated.

2 I understand, I have officially heard
3 that St. Lambert who provides the water supply for three
4 other municipalities, communities nearby, will be
5 fluoridated - fluoridating within a few months so that
6 there, in the Province of Quebec, we would have approxi-
7 mately 21 municipalities that will be applying fluorides
8 covering the population, if I am not mistaken - I am
9 sorry I haven't got the exact figures here, but somewhere,
10 I believe, around 180 or 90, thousand people.

11 THE ACTING CHAIRMAN: Thank you very
12 much. You refer, Dr. Vachon, to the necessity for
13 increasing the number of dentists. I think everybody
14 is in agreement that that is desirable and you suggested
15 it be done through scholarships and awards.

16 We were told this morning, as I recall
17 it, that there were scholarships and bursaries available
18 for students that weren't being taken up, and that there
19 was some other barrier that prevented young, bright
20 young men going into the dental profession rather than
21 into some of the other professions.

22 Would you like to comment on that?

23 DR. LUSSIER: The statement you referred
24 to, the statement made this morning, is perhaps, to
25 English-speaking persons, but I don't think that in the
26 case of the French-speaking, which I represent, it has
27 the same value.

28 We haven't had to date the opportunity
29 to note that students refused scholarships because the
30 number of scholarships available to French-speaking



1 persons is very small.

2 Similarly, the number of loans made
3 available to them. I think that at the present time if
4 it is desired to intensify recruiting action must be
5 taken on plans that will ensure the students' continuity
6 from the beginning of the studies to the end so as to
7 assure them, at least, the school fees and part of the
8 general fees which they have to pay during the four
9 university years.

10 At the present time we have scholarships,
11 provincial government, which covers school fees to a
12 maximum of \$500 for persons from out-of-town and up to
13 \$300 for persons living in Montreal, but this is the
14 maximum and this figure doesn't apply to all students
15 who apply.

16 Sometimes they receive up to \$150 and
17 that isn't taken in the manner of such a scholarship
18 where the student will - account is not taken of the much
19 higher expenses for studies for dental surgery which places
20 faculty in a position of inferiority from the point of
21 view of recruitment of those who may have a choice
22 between a number of faculties or schools.

23 THE ACTING CHAIRMAN: Dr. Lussier, you
24 mentioned scholarships or fellowships from the provincial
25 government. Is the person, the student who accepts that
26 scholarship, under any particular obligation once he has
27 graduated to practise in the Province of Quebec or prac-
28 tise in a rural area in the Province of Quebec or is he
29 quite free?

30 DR. LUSSIER: At the present time the



1 Similarly, the number of loans made
2 available is then, I think that at the present time it
3 is decided to intensify recruitment action must be
4 taken on basis that will ensure the students' continuity
5 from the beginning of the studies to the end so as to
6 ensure that, at least, the school fees and part of the
7 general fees which they have to pay during the four
8 university years.

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11 maximum of \$500 for persons from out-of-town and up to
12 \$300 for persons living in Montreal, but this is the
13 maximum and this figure doesn't apply to all students
14 who apply.

15 Sometimes they receive up to \$150 and
16 these facts taken in the manner of such a scholarship
17 where the student will - second is not taken of the
18 higher expenses for studies for dental surgery which are
19 leading to a position of inferiority from the point of
20 view of recruitment of those who may have a choice

21 between a scholarship or fellowship from the provincial
22 government, in the second, the student who accepts that
23 scholarship, which may involve obligation to be in the
24 service of the government for a certain period of time
25 after graduation. At the present time the



1 granting of the fellowship is not related to the school
2 in which one studies, therefore the student is not
3 bound to practise in one place or the other. The only
4 commitment he has to the Government is to refund 40%
5 of the amount. There are no complete fellowships or
6 scholarships. It is sort of a pre-fellowship plan.

7 THE ACTING CHAIRMAN: But he could
8 then satisfy his obligation to the Government by repaying
9 40% of the fellowship, and then he could move out and
10 practise dentistry in Alberta?

11 DR. LUSSIER: I think so.

12 THE ACTING CHAIRMAN: Now, you recommend,
13 Dr. Vachon, the establishment of Schools of Dental Hygiene
14 in the existing dental faculties. Are there no Schools
15 of Dental Hygiene in the Province of Quebec today?

16 DR. LUSSIER: Thank you, Mr. Chairman.
17 Well, sir, at the present time there are no Schools of
18 Dental Hygiene in the Province of Quebec. There is a
19 School of Hygiene at McGill, at the Montreal University,
20 but the teaching there does not include any program
21 especially for dental hygienists as in America. There
22 is training of dental hygienists in Canada referring to
23 auxiliary personnel specialized to assist certain dentists
24 in the exercise of his profession, so that these students
25 must be trained in dental faculties or schools. Neither
26 in McGill or in Montreal is there any department which
27 trains that type of person.

28 An attempt was made at the U. of M.
29 some ten years ago. It wasn't successful and following
30 that the first school was formed in Canada, that in



1 Toronto, about ten years ago.

2 THE ACTING CHAIRMAN: When you make
3 this recommendation, I take it you must feel that
4 there is a demand for dental hygienists, that they
5 would obtain employment, they would add to the producti-
6 vity of the dentists and make a general contribution in
7 the field of education and in the actual practice of
8 the profession.

9 I put that question to you because it
10 was suggested to us this morning that we might train
11 these people and then nobody would employ them.

12 DR. LUSSIER: Mr. Chairman, in the
13 light of the experiments made in other provinces, and
14 also in the United States, we don't believe that the
15 lack of work of graduate dental hygienists will become
16 a problem. On the contrary, we believe we have to
17 accept the approach which may be levelled at, the training
18 of dental hygienists is - that persons don't remain
19 available long enough, whether they are taken out of the
20 market by marriage or for other reasons,
21 it is no different in any case from the feminine
22 personnel existing elsewhere. I think that in accordance
23 with experiments elsewhere these auxiliaries have been
24 very well received by the dental profession. They are
25 very much in demand and the services they render are
26 heartily appreciated.

27 We don't want the Province of Quebec not
28 having the benefit of the presence of these young ladies.
29 They are numerous already in Ontario and in Nova Scotia
30 and Alberta is already quite noteworthy, quite numerous.



1 THE ACTING CHAIRMAN: Thank you, Dr.
2 Lussier. Just one other point I would like to touch on.
3 You registered your opposition to the immediate establish-
4 ment of another dental faculty in the Province of Quebec
5 and I think you have spelled out in the body of your brief
6 the reasons for that. Would you like to comment on that?

7 DR. LUSSIER: Again I will speak :
8 on this, Mr. Chairman; it is a matter just of opportunity
9 in respect to the future of dental education in the
10 province.

11 At the present time, in the Province of
12 Quebec, there are two dental faculties. It is a situation
13 which doesn't exist in other provinces of Canada. It is
14 well known to maintain two faculties is quite a burden
15 on the State which has to subscribe to most of the expense
16 of these faculties.

17 It is known already that the expenses
18 involved to maintain a dental faculty are probably the
19 highest of any of the schools on a university campus.

20 If another school had to be founded
21 within the immediate years, let us say five or six years,
22 it would become, for the Government, a rather considerable
23 burden.

24 Another problem which requires considera-
25 tion here is that of the teaching staff or faculty. The
26 teaching staff is very difficult to obtain for dental
27 hygiene work, and if a French-speaking school had to be
28 founded in the province it would place the University of
29 Montreal in a very difficult situation.

30 Personnel is managed through - has been



THE ACTING CHAIRMAN: Thank you, Mr.

Chairman. There are other points I would like to touch on. Your registration your opposition to the immediate establishment of another dental faculty in the Province of Quebec and I think you have spelled out in the body of your report the reasons for that. Would you like to comment on that in respect to the future of dental education in the

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another problem which requires consideration. There is a lack of the teaching staff or faculty. The teaching staff is very difficult to obtain for dental training work, and if a French-speaking school had to be founded in the province it would place the Government in a very difficult situation.

Personnel is required in the dental - how can



1 installed by considerable sacrifices on the part of the
2 personnel in the school itself. If a new school is
3 formed the University of Montreal School of Dental
4 Services would have difficulty with personnel with any
5 other school that should be set up.

6 Still in reply to this matter, were a
7 French-speaking faculty, and we are the only one in
8 North America, therefore, if a new one were to be formed
9 in North America the equipment - we can't call upon the
10 other countries or the other American schools, or the
11 other institutions to find a teaching staff for this
12 school. That is the gravity of the problem that would
13 arise if another faculty was set up right away.

14 The faculty of the school is not against
15 it in principle, but in the present circumstances we
16 feel great caution must be exercised, and that is why
17 the recommendation has gone in.

18 THE ACTING CHAIRMAN: Let me ask one
19 more question. Dr. Lussier, can you accommodate more
20 students in the Faculty of Dentistry at the University
21 of Montreal than you are taking in today?

22 DR. LUSSIER: This is the first period for
23 ten years we were at the limit in the past year so we
24 have always had space but we hope to continue to fill
25 it in the future years.

26 THE ACTING CHAIRMAN: Supposing that
27 happens, supposing you do fill all the places in future
28 years as you did in the Fall of 1961; how far is that
29 going to go towards halting the shortage of dentists
30 among the French-speaking population?



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 personnel in the school itself. It is a new school as
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 Services would have difficulty with personnel with any
 other school that should be set up.

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 North America, therefore, if a new one were to be formed
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 other countries or the other American schools, or the
 other institutions to find a teaching staff for this
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 arise if another faculty was set up right away.

The faculty of the school is not again
 it in principle, but in the present circumstances we
 feel great caution must be exercised, and that is why
 the recommendation has gone in.

THE ACTING CHAIRMAN: Let me ask one
 more question, Dr. Master, can you accommodate more
 students in the Faculty of Dentistry at the University
 of Montreal than you are taking in today?

DR. MASTER: This is the first point
 ten years we were at the limit in the past year so we
 have always had space but we hope to continue to fill
 it in the future years.

THE ACTING CHAIRMAN: Regarding that
 question, regarding you do fill all the places in future
 years as you did in the fall of 1961; how far is that
 going to go towards meeting the shortage of dentists



1 Let us put it this way: if you see
2 that you run into great difficulties if you divide the
3 two faculties, split the present faculty into two and
4 put part in Quebec City and part in Montreal, can you
5 more economically expand the present facilities that
6 you have with the present faculty?

7 DR. LUSSIER: I think the ideal situa-
8 tion would be rather an expansion of the present faculty
9 which is not at the limit of the optimum condition from
10 the point of view of numbers. We are teaching up to 85
11 or 90 students a year and still remain within acceptable
12 teaching limits from the point of view of results whereas
13 if another faculty were founded I do not think there
14 would be double the number of students by extending the
15 present faculty.

16 The ideal solution for a number of
17 years would be to increase the availability of the
18 teaching faculty and also the quality of the students
19 should increase.

20 I told you that we accepted 60 students
21 last Fall; this does not mean that we would have had a
22 greater choice because we might not have chosen 60
23 better students than we have accepted.

24 We also have to deal with the problem
25 of quantity and of quality at the ~~same~~ time.

26 THE ACTING CHAIRMAN: What you are
27 saying, in effect, is that you could increase your
28 intake by up to 50% with some expansion of your physical
29 facilities with the present staff and always assuming
30 that the young men of the proper quality are available?



1 DR. LUSSIER: Yes, Mr. Chairman.

2 THE ACTING CHAIRMAN: Are there any
3 women dentists in the Province of Quebec?

4 DR. LUSSIER: We have very few. To
5 my knowledge we have one or two young ladies registering
6 each year and they are usually from immigrant families.

7 In other words, the proportion of
8 young French-Canadian girls, the tendency towards the
9 practice of dental surgery is far from being great.

10 THE ACTING CHAIRMAN: Thank you, Dr.
11 Lussier. Dr. Strachan?

12 COMMISSIONER STRACHAN: I think we
13 should give you a high pass mark on your dental examina-
14 tion, Mr. Chairman.

15 THE ACTING CHAIRMAN: As long as the
16 dentists do not examine me.

17 COMMISSIONER STRACHAN: I would like to
18 go back to the subject of scholarships and have some
19 clarification. In paragraph 14 on page 4 you refer to
20 annual scholarships and at paragraph 20 you say:

21 "There must be instituted a system
22 of scholarships for dental surgery
23 students."

24 Would you explain the connection between
25 these two paragraphs?

26 DR. LUSSIER: Mr. Chairman, the question
27 put by Dr. Strachan is a matter of the relationship
28 existing between the number, the internal number of
29 dentists and the cost of studies. It is in that sense
30 you are asking for clarification?



1 COMMISSIONER STRACHAN: Not exactly.

2 In paragraph 14 you refer to annual scholarships which
3 are in existence at the present time, I presume?

4 DR. LUSSIER: No, at the present time
5 there are no scholarships specifically for the study of
6 dental surgery - there are none.

7 COMMISSIONER GIRARD: May I clarify a
8 little? I think it is a question of fellowships, of
9 aid to youth which the student must refund 40%, not
10 only scholarships only for dental students but all
11 university students and even in schools of nursing.

12 DR. LUSSIER: Yes. To answer Dr.
13 Strachan, the fellowships now existing are available to
14 all students who wish to go to university and no dent
15 is made in the allocation of their scholarships at the
16 government level to the various schools or faculties
17 to which these students go.

18 This is merely assistance to the students
19 who wish to go to university. The only thing that exists
20 in the Province of Quebec in relation to dental surgery
21 is the loans which the Kellogg Foundation has made
22 available to the University of Montreal and McGill
23 University.

24 There is a certain sum which the dental
25 surgeons have made available to loan to students up to
26 \$500 to each student for the whole course. These are
27 the only things existing for students in dental surgery.

28 COMMISSIONER STRACHAN: Then you are
29 suggesting an expansion of scholarships for dental
30 students?

In paragraph 1, you refer to some of the scholarships which

are in existence at the present time. I presume?

LA. LUSITANA: No, at the present time

there are no scholarships specifically for the study of

COMMISSIONER CHANDLER: May I clarify?

little. I think it is a question of fellowship, of

and to youth which the student must return home, and

only scholarships only for dental students and all

generally students and even in schools of nursing.

Yes. To answer that

question, the fellowships now existing are available to

all students who wish to go to university and no limit

is made in the allocation of their scholarships as to

any particular level to the various schools or faculties

to which these students go.

This is merely assistance to the student

who wishes to go to university. The only thing that exists

in the nature of a grant in relation to dental surgery

is the fact which the Kellogg Foundation has made

available to the University of Montreal and McGill

There is a certain sum which the dental

students have made available to loan to students up to

and to each student for the whole course. There is a

the only thing existing for students in dental surgery.

COMMISSIONER CHANDLER: Then you are

not making an explicit list of scholarships for dental

students?



1 DR. LUSSIER: Yes.

2 COMMISSIONER STRACHAN: One other
3 matter I would like to clarify and this may be in trans-
4 lation and I think possibly it is; where you make
5 reference to the teaching of dental surgery in medical
6 faculties. You do not mean there the training of dental
7 hygienists?

8 DR. LUSSIER: No.

9 COMMISSIONER STRACHAN: Nor do you mean
10 that dental hygienists should be trained in the School
11 of Hygiene?

12 DR. LUSSIER: I do not think that the
13 effect originally in the university continent of dental
14 hygienists so far have been drawn either in colleges or
15 in faculties or in schools of dental surgery.

16 I do not know of any schools or faculties
17 of dental hygiene which have to date taken up the
18 training of dental hygienists in the sense in which we
19 understand it; that is to say, a young lady working as
20 an auxiliary in a dental office or in dental education
21 generally.

22 COMMISSIONER STRACHAN: May I repeat
23 the question which I put to the group this morning that
24 you would place the public education in matters dental
25 in a very preferred position? Is that not one of the
26 first things which should be accomplished? You
27 mention dental education or education of the public;
28 is that not of prime importance?

29 DR. deMONTIGNY: Mr. Chairman, our
30 Society believes that public education in dentistry is



1 very important in Montreal and in the Province of Quebec
2 because every day our clinics and our offices give us
3 the opportunity to see patients whose teeth are in a
4 deplorable state and this constitutes a great part of
5 the population.

6 We believe, therefore, that an intensive
7 educational campaign in dental hygiene could be organized,
8 not on a temporary basis but on a quasi-permanent basis
9 because the population, and I repeat this, has very
10 little knowledge about dental hygiene.

11 We believe that dental hygiene education
12 is of great importance in this province.

13 COMMISSIONER STRACHAN: I take it in
14 the same sense you feel that more dental hygiene, to
15 use your term, should be taught in medical schools as
16 well as in schools of hygiene?

17 DR. deMONTIGNY: When we speak in our
18 brief of the teaching of dental hygiene in the medical
19 schools we mean that we hope that the medical profession
20 realizes this problem with respect to dental hygiene
21 because the physician must collaborate with the dentist
22 in dealing with the health of the population.

23 We should like to see the physician
24 instructed and taught about the problem that is consti-
25 tuted by dental hygiene.

26 We believe that there is no such provi-
27 sion made in the present curriculum for medicine for
28 teaching dental hygiene.

29 COMMISSIONER STRACHAN: Now, under the
30 suggested organization for dental care, on page 11,



1 paragraph 10, you say:

2 "Service provided by specialists
3 would be called in only if patients
4 are referred to them by general
5 practitioners."

6 Who would pay for these services?

7 DR. deMONTIGNY: We include this
8 clause to solve a problem which might arise if a system
9 of health insurance were established in our country.
10 The predominant idea behind this is probably if a system
11 of health insurance were adopted there would also be a
12 list of fees that would be established and this list of
13 fees would apply to specialists recognized by the appro-
14 priate professional organization.

15 These fees would, of course, be slightly
16 higher with respect to specialist treatments. We have
17 stated here these specialists would be paid at the rate
18 given in this scale of fees which would be higher if
19 the patient was referred to by the general practitioner.

20 In other words, we do not want the
21 specialist to treat people directly and to do a task
22 which perhaps the general practitioner can undertake at
23 a slightly lower rate.

24 DR. VACHON: May I add something, sir?
25 The purpose of this measure is to protect the public
26 which would go to a general practitioner and the practi-
27 tioner may ask for a fee which would be appropriate to
28 a specialist whereas he would only be a general practi-
29 tioner.

30 COMMISSIONER STRACHAN: Specialists



1 then, I presume, from what you say, would be paid by the
2 same means as the general practitioner?

3 DR. VACHON: Yes, as far as possible
4 the specialist would be paid from the same source as
5 the general practitioner is paid.

6 COMMISSIONER STRACHAN: Referring to
7 the sentence at the bottom of page 11, where you mention
8 consideration of the imposition of tax on food or
9 beverages which are not essential and which favour
10 dental caries, who might I ask would decide whether
11 they were essential or not?

12 DR. deMONTIGNY: Dr. Strachan, you have
13 asked who would decide whether a particular beverage is
14 harmful to the teeth?

15 COMMISSIONER STRACHAN: That is so.

16 DR. deMONTIGNY: Well, obviously this
17 decision could surely be made upon the advice of the
18 dental profession by means of research. This recommenda-
19 tion could be made by recommendation to the Government
20 or the Minister of Health with the assistance of one of
21 its offices and could take a decision on whether or not
22 a particular beverage was not beneficial to health and
23 also it could decide whether or not a particular beverage
24 was harmful to health.

25 COMMISSIONER STRACHAN: I apologize
26 for being a bit confusing to you because the translation
27 does not quite correspond. I hadn't appreciated that
28 fact. I think, Mr. Chairman, that is all.

29 THE ACTING CHAIRMAN: Thank you, Dr.
30 Strachan. Miss Girard?

them, I presume, from what you say, would be paid by the
State as the general practitioners?

Dr. VACHON: Yes, as far as possible.

The specialist would be paid from the same source as

the general practitioners, is paid.

COMMISSIONER STRACHAN: Referring to

the sentence at the bottom of page 11, where you mention

consideration of the imposition of tax on food or

beverages which are not essential and which involve

double taxation, who might I ask would decide whether

they were essential or not?

Dr. DEMONTGNEY: Dr. Strachan, you have

asked who would decide whether a particular beverage is

harmful to the body.

COMMISSIONER STRACHAN: That is so.

Decision would surely be made upon the advice of the

medical profession by means of research. This recommendation

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or the Minister of Health with the assistance of one of

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a particular beverage was not beneficial to health and

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was harmful to health.

COMMISSIONER STRACHAN: I suppose

for being a bit confusing to you because the Commission

does not quite correspond. I hadn't appreciated that

fact. I think Mr. Chairman, that is all.

THE ACTING CHAIRMAN: That was all.

Thank you, Miss Girdle.



1 COMMISSIONER GIRARD: Mr. Chairman,
2 you mentioned public education in dental hygiene. Now,
3 I believe that you are aware that there is a certain
4 dental hygiene campaign undertaken by Montreal dentists.
5 This is a very elaborate campaign. Did you mention,
6 when you were speaking a few minutes ago, or did you
7 simply refer to the teaching of dental hygiene in the
8 medical schools? I am referring to hygienists who
9 teach this subject in the schools of hygiene, and not
10 necessarily in the schools of the School Commission.

11 What the League for Dental Hygiene
12 is doing. This is what I am referring to.

13 DR. BOUILLON: Does your question call
14 for an answer as to present education which is being
15 undertaken at all levels, because as you know the
16 health service itself has a program of health education
17 with respect to dental diseases.

18 In the Province of Quebec there are
19 eight specialized dental hygiene specialists who do
20 carry on educational work in professional societies,
21 and in organizations such as the Lions' Club, etc., as
22 well as among educational groups, and with certain
23 nursing societies, and within nursing schools.

24 Work is being done on a very considerable
25 scale, but as Dr. deMontigny has stated this work is at
26 its very inception, and it should be continued and
27 amplified, because with respect to dental hygiene it is
28 at the educational level that we can secure greater
29 co-operation in reducing dental illnesses. This, of
30 course, would promote a more effective solution to the

...in the public education in dental hygiene. Now,
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when you were speaking a few minutes ago, or did you
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undertaken at all levels, because as you know the
Institute itself has a program of dental education
with respect to dental diseases.

In the Province of Quebec there are
eight specialized dental hygiene specialists who do
carry on educational work in professional societies,
and I organizations such as the French Club, etc., as
well as many educational groups, and with contacts
existing societies, and within existing schools.

There is being done on a very considerable
scale, but as Dr. Delaney has stated this work is at
the very inception, and it should be continued and
amplified, because with respect to dental hygiene in
at the educational level that we are secure present
cooperation in reducing dental diseases. This, of
course, would promote a more effective action for the



1 problem existing.

2 COMMISSIONER GIRARD: If you would like
3 to refer to that phase of work, which was not mentioned,
4 but now I have another question concerning your sphere
5 of activity.

6 This concerns the work done in the
7 schools of the Montreal School Boards, particularly in
8 the health service department. This morning a question
9 was raised as to who hired dentists in these schools.
10 That is, dentists dealing with school hygiene. A satis-
11 factory reply was not given.

12 Now I want to give you the opportunity
13 of furnishing a satisfactory reply.

14 DR. BOUILLON: The hiring of personnel
15 in the health services is something which depends on
16 the budget. Now, the budgetary provisions of each
17 department head are submitted, and the personnel are
18 hired on the basis of these estimates.

19 If the budget permits, then the recom-
20 mendations of the director of a department are followed,
21 and additional dentists are hired on a pro rata system,
22 depending on the requirements for dentists that are
23 submitted to the personnel offices.

24 Now, lists of eligibility are set up
25 on the basis of these applications. These lists are
26 submitted to the health services, and suitable candidates
27 selected from these lists.

28 COMMISSIONER GIRARD: These dentists
29 are hired by the health services. This was not stated
30 this morning.



1 DR. BOUILLON: Yes, they are hired on
2 a permanent basis.

3 COMMISSIONER GIRARD: Now, with respect
4 to dental hygienists, I am sure, and if I am not right
5 you will tell me so, but if there is a school of dental
6 hygienists in a dental school, would you be ready to
7 employ these dental hygienists in dental clinics, and
8 in schools of the School Board, instead of nurses?

9 DR. BOUILLON: Well, I believe the
10 health service would certainly accept such people
11 without any restriction, because at the present time
12 in our clinics we have several registered nurses to
13 assist the dentists in their work.

14 These people are obliged, since they
15 are not prepared for actual dentistry work, they are
16 obliged to be trained as if they were simple assistants,
17 but naturally they have much greater knowledge than a
18 simple assistant, and they give a considerable service
19 with respect to education on food, etc., and another
20 factor which would promote the participation of hygienists
21 instead of nurses is that there is an ever-growing need
22 of nurses for the various consultation services in the
23 schools.

24 Now, these nurses who would not be
25 needed would be utilized by other services. Therefore,
26 we would have dental hygienists perhaps at a lower
27 salary than the nurses at present.

28 COMMISSIONER GIRARD: Well, this would
29 serve for both professions, because you could have a
30 greater number of people, and they would be more quickly



1 trained. These people could give services which would
2 be more adequate to the needs, and the nurses would
3 recuperate members of their own profession to work
4 elsewhere.

5 DR. BOUILLON: Then there is another
6 point; the use of dental hygienists can be carried on
7 in schools, and also for certain clinical services.
8 Now the nurses could not do this.

9 COMMISSIONER GIRARD: Let us take, for
10 example, the application of fluoride treatment. What
11 are the duties that you would entrust to your dental
12 hygienists?

13 DR. BOUILLON: Well, these are the
14 duties that would be decided on by the College of
15 Dentists. We know in the State of New York in the U.S.A.,
16 and New Jersey, the dental hygienists make topical appli-
17 cations of fluoride.

18 They also conduct examinations, and
19 they carry out certain prophylactic treatment. In
20 other words, they do work that would free the dentist
21 for the corrective and remedial treatment.

22 COMMISSIONER GIRARD: What prevents
23 the Faculty of Dentistry of the University of Montreal
24 from setting up this School of Dental Hygiene, which
25 was mentioned some ten or twelve years ago, particularly
26 at a time when there was a person ready to take charge
27 of this department?

28 DR. LUSSIER: Well, you give me the
29 opportunity to come back to some old memories. What
30 prevented the school to set up such a department at that



1 time? It was, I believe, due to certain indifference
2 of the dental profession at that time in expressing
3 its desire, its clear desire, to accept such a branch.
4 This was about twelve years ago. This idea was some-
5 thing which had not been accepted in Canada, and the
6 profession, I think, in Quebec was not ready to take
7 this initiative, and this is what delayed the implementa-
8 tion of this idea.

9 The person who you mentioned was, of
10 course, snatched by the Dental Faculty in Toronto and
11 was immediately put to work. For this reason that
12 school was set up first in Toronto.

13 At the present time the situation is
14 different. Since last February the College of Dental
15 Surgeons has finally accepted a certain number of provi-
16 sions relating to the exercise of the dental hygiene
17 profession in Quebec, but prior to 1962 the exercise
18 of this profession was not authorized in Quebec, so as
19 long as this profession could not be exercised it was
20 futile for the School of Dentistry to do anything for
21 the purpose of setting up such a school, since this
22 profession had not yet been recognized, but now that
23 this obstacle has been removed we have a green light
24 to go ahead.

25 COMMISSIONER GIRARD: You perhaps
26 could obtain from the University of Toronto that person
27 in order to work here in Montreal?

28 DR. BOUILLON: I believe that you
29 misunderstood me when I said it was the health services
30 which hired these personnel. It was the Executive



1 Committee which hires personnel, upon the recommendation
2 of the Director of the health services.

3 COMMISSIONER GIRARD: Well, I simply
4 wanted to ascertain the fact that the dentists were
5 furnished by the health services. The reply made this
6 morning was not clear, and I wanted to give you the
7 opportunity to speak on the same point this afternoon.

8 COMMISSIONER BALTZAN: Mr. Chairman,
9 I hope you will be glad to hear that I haven't got a
10 toothache, but I have been developing a little bit of
11 dental trouble concerning some things, concerning the
12 matters contained in these submissions.

13 To continue from where the Commissioner
14 left off, No. 30, on page 6, with regard to the dental
15 hygiene school. I have only one question. Do you mean
16 there entirely a separate, independent school just for
17 that purpose, or do you mean a department in your
18 Faculty of Dentistry?

19 DR. LUSSIER: I believe that what we
20 have in mind here is some kind of assistance to establish
21 a school which would not be an independent school; it
22 would be a school placed under the direction, placed
23 under the administration, at least partially, of the
24 Faculty of Dental Surgery.

25 The profession of dental hygienists
26 is not an independent profession. It is a profession
27 which is covered by the dental legislation, and I believe
28 the training of this type of personnel should be subordi-
29 nated to the dental faculties, so that there would be an
30 integration of the teaching in these branches which would



1 bring together both parties involved in the matter.

2 COMMISSIONER BALTZAN: Would that
3 correspond with the method of, say, training x-ray techni-
4 cians, or laboratory technicians, as it is being done in
5 the medical schools?

2 6 DR. LUSSIER: I don't think so. This
7 is a profession which is more personally in contact
8 with the public, or at least with the same public that
9 the dentist himself deals with.

10 Radiologists, for example, and other
11 technicians under the Faculty of Medicine cannot be
12 compared with dental hygienists. The latter gives
13 care to patients which belong to a clientele, he belongs
14 to the dentist, and is paid by the dentist, but he does
15 not do his work in the presence of a dentist, and this
16 is different to the other cases.

17 The other cases depend on doctors of
18 course, but they work with doctors at the hospitals.
19 The dental hygienists are people who help the dentist
20 work in his own private office.

21 COMMISSIONER BALTZAN: They haven't got
22 an office of their own, and work with a dentist, and
23 don't treat people independently?

24 DR. LUSSIER: No.

25 COMMISSIONER BALTZAN: So that there is
26 some kind of resemblance with those other two types of
27 technicians that I mentioned? Thank you for telling me
28 that.

29 I just want to turn to page 8, and 38,
30 not reading the whole paragraph, merely to refer to (e),



1 integration of dental hygiene instruction in the facul-
2 ties of medicine. My question is, is this not actually
3 a matter of inter-faculty relationships, that this is
4 not a matter for national regulation or direction? It
5 is a question of understanding between the faculties
6 of dentistry and the faculties of medicine, or is it?

7 DR. LUSSIER: I do believe that this
8 is an observation which will reinforce the argument
9 put forward here, namely that dental education, if we
10 want it to be undertaken in a profitable way, and a
11 good and a thorough manner, I believe all the sectors,
12 all persons responsible for public health, should be
13 informed of it.

14 Now, if there are any gaps, or lacks
15 with respect to other faculties, they should be investi-
16 gated and there should be understanding in the inter-
17 faculty relationships.

18 This understanding should be felt at the
19 higher levels, to make dental education as broad as
20 possible.

21 COMMISSIONER BALTZAN: You include in
22 that instruction and demonstrations as between the
23 faculties?

24 DR. LUSSIER: I believe that if it was
25 simply left to the discretion of the faculties there
26 could be a certain improvement, but if it is suggested
27 that not only at the level of the faculties, but also
28 at the level of both professions, measures could be
29 taken to achieve a unity of action with respect to
30 dental education, this would be much better, and this



1 action should begin at the university, that is with
2 respect to both the dental and the medical professions.

3 COMMISSIONER BALTZAN: It might be a
4 good place to start to force every medical student to
5 go and see a dentist and learn something about the thing.

6 Finally, on page 9, 45:

7 "Only one-third of the population
8 regularly pays a visit to the
9 dentist. It may be regarded that
10 perhaps this small percentage, again
11 because they can afford it, because
12 they can reach a dentist, etc., and
13 that the other two-thirds cannot go
14 there because they haven't got the
15 money to pay for it."

16 Is that what you mean, or is there
17 something broader?

18 DR. deMONTIGNY: What we meant by that,
19 sir, was only one-third of the population undergoes
20 regular dental treatment. This does not mean people
21 who do not go to the dentist occasionally, but in two-
22 thirds of the cases they only go for emergency treatment.
23 Well, sometimes they go for an extraction and so on, but
24 for permanent treatment only one-third of the population
25 does go regularly to the dentist.

26 These figures are taken from a study
27 made some two years ago, I believe, by the Canadian
28 Dental Association, which circulated a questionnaire to
29 all Canadian dentists, and these figures result from
30 this inquiry.

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all dental dentists, and these figures result from



1 Perhaps the situation in Montreal is
2 even worse than given here, but for the motives that
3 you mentioned a few minutes ago, for economic reasons,
4 for questions of education, and perhaps due to the lack
5 of dentists in certain areas this situation does obtain.

6 COMMISSIONER BALTZAN: Just to finish
7 this last statement, we have heard elsewhere that where
8 there were sufficient dentists, and they were available,
9 there is no great distance for interference with acces-
10 sibility, and where people had the finances, the economic
11 means to obtain dental services, and those who didn't
12 have the means but had provision through public assis-
13 tance; even this group only about one-third attended
14 dentists, other than the prophylactic regular routines.

15 Now, is that something to do with the
16 lack of information, or fear on the part of the public,
17 that keeps two-thirds of the people who need dental
18 care away?

/dpw 19 DR. deMONTIGNY: In the main course it
20 is to be found in the economics here and the sphere of
21 education also, because there are other factors involved,
22 but the two main ones in our opinion are the two I have
23 mentioned, economics and educational courses.

24 THE ACTING CHAIRMAN: What you are
25 really saying, Doctor, there are a lot of people who
26 don't want to go to the dentist whether they can afford
27 it or not?

28 DR. deMONTIGNY: The idea is that there
29 are certain people who can afford the care that they
30 need but don't bother about it. Those persons would



1 come into the category of persons who don't attach the
2 importance they should attach to the care of their
3 dental cavities.

4 THE ACTING CHAIRMAN: To solve that
5 problem you are recommending broad education in the
6 importance of oral hygiene?

7 DR. deMONTIGNY: Yes sir.

8 THE ACTING CHAIRMAN: Dr. Firestone?

9 COMMISSIONER FIRESTONE: Dr. Vachon,
10 I feel that the Dental Association of Montreal is to be
11 congratulated for having come forward with a concrete
12 proposal to introduce a dental health insurance plan
13 and the proposal of priorities, of how to implement
14 such a plan. Do I understand, Dr. Vachon, Mr. Chairman,
15 that is the plan proposed for the Province of Quebec?

16 DR. VACHON: Yes, Mr. Chairman,
17 the plan proposed by La Société dentaire
18 de Montréal is a plan to be applied in the Province of
19 Quebec and we believe that after some research and
20 under certain conditions certain insurance plans would
21 assist greatly in improving oral health in our province.

22 COMMISSIONER FIRESTONE: I take it, Dr. Vachon, you might feel
23 perhaps, and that your Society might feel, that a similar
24 plan embodying somewhat similar principles might be
25 adopted in other provinces of Canada so that people
26 moving from one province to another would be assured
27 of a minimum of dental health services whatever their
28 income and social status may be?

29 DR. VACHON: Yes, we believe it would
30 be more practicable than a flat insurance plan available
for the entire population, whatever individual income



1 may be.

2 COMMISSIONER FIRESTONE: And wherever
3 they may be located.

4 DR. LUSSIER: We haven't considered
5 in the recommendations before you whether this should
6 be a plan applicable nationally. We thought in terms
7 of the province because at the present time health
8 is a matter for the provincial administration and the
9 laws which deal with health are at that level.

10 We were interested in provincial so
11 that we didn't understand our recommendations as being
12 in the sense of national application.

13 COMMISSIONER FIRESTONE: I see. Dr.
14 Vachon, I quite understand that your proposals are
15 primarily applicable to the Province of Quebec. The
16 fact, however, remains that people move from one
17 province to another. Would you not feel that if such
18 a plan existed only in the Province of Quebec that
19 people may be somewhat hesitant to move to other provinces
20 even if it is in the interest of the Canadian economy
21 for people to move around in a search for better jobs
22 and other opportunities they may have in other parts of
23 the country; therefore you may have some views; wouldn't
24 it be desirable to have a minimum service, not only in
25 your province, but into the other provinces following
26 the principles which you have outlined.

27 Have you any views on this subject,
28 Dr. Vachon?

29 DR. deMONTIGNY: We believe, sir, that
30 a health plan should be provincial and we understand, on



1 the other hand, persons who move from one province to
2 another might suffer from some disadvantage if the
3 plan were adopted in Quebec only.

4 This situation will be similar to that
5 which may exist, for instance, in other fields which
6 are connected with health, and which are different
7 from province to province.

8 For example, in Quebec we have our own
9 system of labour insurance which is not the same as
10 that in other provinces, for accidents at work. We
11 also have our own system of public aid whereby the
12 municipality or provincial government pays for the
13 hospitalization of persons who are indigent.

14 I have the impression that our system
15 is not necessarily the same as exists in other provinces.
16 The system therefore might be different from that that
17 exists elsewhere, and I don't feel it should play any
18 great part in the reasons which would cause people to
19 move or to go to Quebec Province to have dental care
20 carried out.

21 COMMISSIONER FIRESTONE: I wonder, Dr.
22 Vachon, whether you have any further comments on this
23 question?

24 DR. VACHON: No.

25 COMMISSIONER FIRESTONE: May I then move to
26 another aspect of your proposed plan, sir? You say in
27 paragraph 51, sub-section 6, that the patient would pay
28 for their treatment and would be reimbursed by the State.
29 How would indigent persons pay for their services?

30 DR. LUSSIER: In that section we don't

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The system therefore might be different from that there
exists elsewhere, and I don't feel it should play any
great part in the reasons which would cause people to
move or not to move. Quebec Province to have dental care

COMMISSIONER PRESIDENT: I wonder, Dr.
Vaughan, what do you have any further comments on this

Dr. Vaughan: Yes.

COMMISSIONER PRESIDENT: May I then now

another aspect of your proposed plan, and? You say in
paragraph 51, and section 6, that the patient would pay
for their treatment and would be reimbursed by the State.
How would indigent persons pay for their services?

Dr. Vaughan: In that section we don't



1 go any further than the field of general principles.
2 We are not in a position to propose methods of payment,
3 or any machinery for payment of fees. We simply wish
4 to bring out the fact that we prefer to see the govern-
5 ment or the paying body transact the matter with the
6 patient rather than with the dentist, who, in that
7 case, could rapidly have too much administrative work
8 to prevent him from exercising his professional duties,
9 to prevent him from excessive red tape.

10 As regards the matter of needy people
11 it is there, again, difficult to establish anything
12 further than principles; that is, we wish to take
13 nothing on certain categories of needy people in
14 connection with the service they need.

15 Those services could be called upon
16 up to the establishment of an organization which would
17 touch the state of indigents, of such people. I think
18 we could go no further in the categorizing of persons
19 who should be subsidized.

20 COMMISSIONER FIRESTONE: I can under-
21 stand that, and if we can discuss the whole proposal
22 in terms of principles rather than in details, if I
23 understand you correctly from your paragraph 51, 6, it
24 provides, that paragraph, the patient to pay for the
25 treatment and be then reimbursed by the State. Am I
26 correct in that understanding?

27 DR. LUSSIER: I think that the meaning
28 of the word patient, that may be the person, the reci-
29 pient, the person who receives the fees, - if it is the
30 patient himself, but if it is a child that is involved



1 in the care, it is a person involved, responsible for
2 the child. It is not necessarily stated all adults are
3 in the plan, all adults may be treated.

4 " COMMISSIONER FIRESTONE: If you can
5 help me to understand paragraph 51, sub-paragraph 6,
6 are you referring here to patients who can afford to
7 pay for the treatment, that they make payments and they
8 are reimbursed?

9 DR. LUSSIER: I think it is indicated
10 here that in the sense of a patient receiving care,
11 those who are sent for care according to the plan - as
12 the plan is not definite it is difficult to note who is
13 involved, but there again it is a person who would be
14 sent for subsidized treatment or care.

15 That care should be paid for in toto
16 or in part by the person who would be the recipient of
17 such treatment, who would undertake payment.

18 COMMISSIONER FIRESTONE: How would the
19 indigent person get any money to pay the dentist? How?

20 DR. LUSSIER: In that case - I think
21 there are social agencies which exist in any case and
22 which may come into the picture and take up the commit-
23 ments on behalf of those persons who need care. It
24 would be a third party, a third party, legal person or
25 organization who would come into play.

26 COMMISSIONER FIRESTONE: In other words,
27 you would visualize two groups of people: those that can
28 pay for their service and those that couldn't, and those
29 that couldn't, you have examined by one organization or
30 the other as to whether they are indigent or not, undergo



1 a means test, and if they are so found, issued with a
2 card, gets examined by the dentist and this particular
3 organization would arrange for the payment for the
4 "indigent; is that correct, sir?"

5 DR. LUSSIER: Yes.

6 COMMISSIONER FIRESTONE: Sir, you say
7 in paragraph 51, sub-paragraph 6, that the patients
8 who pay for this treatment would be reimbursed by the
9 State. Where would the State get the money from?

10 DR. deMONTIGNY: Mr. Chairman, I think
11 it is not for us to indicate to the Government where to
12 find the money. The Government, in the past, has always
13 been able to find means of obtaining funds when they
14 were required. Our duty as a profession is to note
15 certain gaps within our population. I think the duty
16 of the Government is to find the funds to fill in those
17 gaps. That is the meaning we have.

18 COMMISSIONER FIRESTONE: Well, I quite
19 understand that you don't wish to get involved in any
20 details or specific proposal. What we here are concerned
21 with is just to understand how the plan which you are
22 putting forward would work. Do you have in mind that
23 the people in the Province of Quebec contribute to a
24 fund which the State would use to reimburse the patient?

25 Do you have in mind an insurance fund
26 to which the people of the Province of Quebec would
27 contribute, say, premium payments?

28 DR. LUSSIER: At the present time we
29 have taken no action on the subject of the plan itself, which
30 leaves us indefinite for the present because we have



1 studied on the level of principles.

2 These matters concern our health. We
3 are interested in establishing, so to speak, the
4 parties involved and then in assigning certain responsi-
5 bility. Thereafter we haven't given any thought to the
6 problem.

7 COMMISSIONER FIRESTONE: You understand,
8 sir, this Royal Commission, Dr. Vachon, is here to
9 advise the Canadian Government as to what sort of plans
10 are feasible and practical and we appreciate that your
11 Association may not have given any thought to any
12 specific details of implementing the plan, but you must
13 have some idea how the plan will be paid for. Would it
14 be paid for by the people that are covered by the plan
15 like any insurance plan?

16 Would it be paid out of taxes? Would
17 it be paid from subsidies; some general idea must be in
18 the back of your mind. You are making it very difficult
19 for this Commission to develop some recommendations
20 based on the plan if we don't understand your thinking.

21 Can you help us to explain your own
22 proposal a little better?

23 DR. LUSSIER: Well, I would reiterate
24 an earlier reply I gave inasmuch as a group we haven't
25 gone into detail on this. We have widely differing
26 opinions. Some are in favour of a certain plan such as
27 those already in use by the U.S. unions, for instance.

28 Others may propose a similar plan where
29 there is a third party. In the States I think it is
30 based on the amount of care given with the treatment



1 scale according to the luxurious character of the care
2 given.

3 " The scope of the plan is so great that
4 special consideration would have to be made upon that
5 question. We haven't had time to develop our analysis
6 there.

7 DR. VACHON: If I may continue what
8 Dr. Lussier has said, we would like to propose something
9 positive. We, of course, realize dental health is very
10 much neglected. It is one of the most widespread
11 diseases and in the Dental Society, professional people
12 wish to contribute in some way to the improvement of such
13 health.

14 We have, therefore, proposed to you
15 certain suggestions. We want something positive. We
16 haven't gone into subsidies because, first of all, as
17 Dr. Lussier has said, we didn't have time, and we no
18 doubt haven't the necessary competence and we believe
19 that the Government have specialized services in
20 research and statistics which will permit them to arrive
21 at accurate results, and in addition they might easily
22 find a solution which would be acceptable both from the
23 point of view of the profession, the quality of work,
24 the point of view of improvement of health of the popula-
25 tion.

26 DR. GREGOIRE: Mr. Chairman, the
27 question you have put is a very difficult one. You ask
28 us where to get the money to pay for that treatment.
29 You know what difficult the various ministers in Ottawa
30 have. Everybody raises that question; where is the money



1 coming from? Even Mr. Fleming wonders where the money
2 is coming for the deficit for next year. So the question
3 which you have raised in the last few minutes seems
4 everything is hinging on money.

5 Since the banks are organizations
6 which have the money, make loans, I think it would be
7 in order to ask the banks this question, where these
8 gentlemen should find money to finance.

9 After all, we are specialists in dental
10 art, and not in money whereas the bankers are the gentle-
11 men who are specialists in money matters.

12 COMMISSIONER FIRESTONE: But the bankers
13 don't practise medicine and dentistry.

14 DR. GREGOIRE: We practise dentistry,
15 but we don't loan money in our office. It is a difficult
16 matter as to where the money is to come from for the
17 indigent people. We don't manufacture money for the
18 people so it is a matter for the bankers or economists.

19 COMMISSIONER FIRESTONE: Dr. Vachon,
20 I want to say you have made a very appropriate remark
21 when you state you want to make a positive contribution
22 to the consideration - the consideration by this Commis-
23 sion.

24 You realize that this question of
25 finance is an important one and I quite appreciate that
26 the dental profession are not experienced in financing.

27 On the other hand, you may have certain
28 basic principles in mind that you might be able to
29 communicate to us, not at this time, but perhaps at
30 another time, and I was wondering would it be possible



1 for you, Dr. Vachon, and your colleagues, to consider
2 the question a little bit more in specific terms; how
3 the plan you have put before us could be implemented
4 in a practical manner?

H/dpw 5 The thought I would like to leave with
6 you is, if you do not get advice from the dental profes-
7 sion we will have to get advice from other people but
8 we would prefer to have the views of the dental profes-
9 sion how their own ideas can be put into practice.

10 DR. LUSSIER: Up to the present a
11 matter which has come to our attention for some years
12 concerning the implementation of the means of refunding
13 dentists for care given to the population who cannot
14 pay their bills has constantly reverted too. The
15 complaints, as I have indicated earlier, are various.

16 The Canadian dentists interested in
17 this matter in the Province of Quebec have indicated in
18 the past that they have some sympathy with a plan which
19 was implemented by France which seems to have yielded
20 satisfactory results.

21 We do not say this is superior to the
22 other plans but we say by our knowledge of it it seems
23 to reach a certain number of objectives and objectives
24 which would cause us some concern if the plan were put
25 into effect.

26 There is one which requires participating
27 to contribute directly or by some agency to the costs
28 and if the plan was brought in we would have one that
29 we would have priority to say that the plan would employ
30 in its principle three groups of persons, the group of



1 patients, the group of operators, that is the dentists
2 themselves and a third group which is considered the
3 partially financed or poor. I do not think we can go
4 any further than that in that direction.

5 COMMISSIONER FIRESTONE: Thank you for
6 your explanation.

7 THE ACTING CHAIRMAN: Thank you very
8 much, Dr. Vachon and gentlemen. Is there anything that
9 anyone would like to add now? I can just say with regard
10 to the point that Dr. Gregoire raised that probably the
11 Royal Commission on Banking may answer that. Thank you
12 very much indeed, gentlemen, we appreciate very much the
13 time and effort you have spent in preparing this submis-
14 sion and you are to be congratulated on it. This will
15 receive our careful consideration.

16 SUBMISSION OF THE ASSOCIATION OF OTOLARYNGOLOGISTS
17 OF THE PROVINCE OF QUEBEC

18 Appearances: Dr. W.J. McNally
19 Dr. F. Montreuil

20 THE ACTING CHAIRMAN: The next submission
21 will be Exhibit No. 214 and the English version will be
22 Exhibit 214A.

23 --- EXHIBIT NO. 214: Submission of The Association of
24 Otolaryngologists of the Province
of Quebec.

25 --- EXHIBIT NO. 214A: English version of submission of
26 The Association of Otolaryngolo-
gists of the Province of Quebec.

27
28 THE ACTING CHAIRMAN: Are you going to
29 make the initial submission, Dr. McNally?
30

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themselves and a third group which is considered the
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any further than that in that direction.

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--- EXHIBIT NO. 214A: English version of submission of
The Association of Otolaryngologists
of the Province of Quebec.

THE ACTING CHAIRMAN: Are you going to

make the official submission, Dr. McElroy?



1 DR. McNALLY: I would imagine Dr.
2 Montreuil would do the French one.

3 THE ACTING CHAIRMAN: Thank you very
4 much. If you would like to summarize your conclusions
5 and recommendations in your brief.

6 DR. MONTREUIL: Mr. Chairman and members
7 of the Royal Commission on Health Services: the summary
8 of the brief we have submitted on behalf of the Associa-
9 tion of Otolaryngologists of the Province of Quebec.

10 First, it is brief and shows some of
11 the needs with respect to medical services. Secondly,
12 the specialization of otolaryngology must develop in
13 order to meet its new needs.

14 Thirdly, the deficiencies in this field
15 are as follows:

- 16 1. Lack of medical and para-medical
17 personnel.
18 2. Lack of facilities for training
19 personnel, research work, identifica-
20 tion of incipient defects and diagnosis
21 and treatment of defects.

22 Our recommendations are:

- 23 1. An educational program to accelerate
24 the recognition of incipient signs and
25 symptoms of disease.

26 The training of new specialists in
27 otolaryngology.

- 28 2. Expansion of facilities:

- 29 (a) In the present centres and
30 (b) by establishing new centres for



Dr. McNally: I would like to say that

Montreal is the first of the kind.

THE ACTING CHAIRMAN: Thank you very

much. It would like to summarize your conclusions

and recommendations in your report.

MR. MONTREAL: Mr. Chairman and members

of the Royal Commission on Health Services: The summary

of the brief we have submitted on behalf of the Association

of Otolaryngologists of the Province of Quebec.

First, it is brief and shows some of

the needs with respect to medical services. Secondly,

the specialization of otolaryngology must develop in

order to meet its new needs.

Thirdly, the deficiencies in this field

are as follows:

1. Lack of medical and para-medical

personnel.

2. Lack of facilities for training

tion of hereditary defects and diagnosis

and treatment of defects.

Our recommendations are:

1. An educational program to develop

the recognition of hereditary defects and

symptoms of disease.

The training of new specialists in

otolaryngology.

2. Expansion of facilities

(a) in the present context and

(b) by establishing new centers for



1 the rural areas.

2 (c) In teaching and research programs.

3 There is need for increased financial
4 support for the above.

5 THE ACTING CHAIRMAN: Is there anything
6 you would like to expand on in summary? Is there any-
7 thing that you want to place particular emphasis on?

8 DR. MONTREUIL: We have stressed the
9 lack of qualified personnel, medical personnel as well
10 as lack of clinical facilities and also the lack of
11 educational facilities for our specialization. We have
12 also stressed lack of research facilities.

13 Our second point is that we should
14 like to stress the importance of education and diagnosis
15 of the pathological symptoms with respect to the children
16 particularly.

17 DR. McNALLY: That, of course, is of
18 great concern in Canada, the importance of detecting
19 hearing losses early and particularly in children, is
20 of great importance, not only because of the hearing
21 involved but we are, of course, equally concerned about
22 the acquiring of language and language development.

23 Of course, we realize there are other
24 causes that interfere with language development over
25 and above hearing but we do feel that we must have ade-
26 quate diagnostic facilities in order to understand very
27 early just what the problem is in any particular child
28 so that we must have well-qualified people and diagnostic
29 centres that can unravel some of this very complex
30 problem involving, in some cases, hearing and in other



1 cases brain damage and other things which could interfere
2 with the child learning and developing the language.

3 THE ACTING CHAIRMAN: You refer in
4 your brief as you just mention now the lack of qualified
5 personnel, particularly medical personnel; what is the
6 reason why there is no great specializing in this field?

7 DR. McNALLY: Well, Mr. President, that
8 is a difficult question to answer. My own feeling is
9 that immediately after the antibiotics were discovered,
10 a lot of medical people particularly thought that the
11 specialty of otolaryngology might be rather seriously
12 curtailed.

13 These opinions, I think, were expressed
14 rather freely in medical schools with the result that
15 medical students were certainly not encouraged to study
16 the specialty of otolaryngology. Unfortunately the
17 result has been a lack of well-trained people. The
18 other point that I think is important is that the anti-
19 biotics instead of curtailing the specialty have actually
20 made it possible for the specialty to branch out into
21 fields that were previously not safe ones.

22 For instance, we have operations on the
23 internal ear or labrinth, which is now done fairly regu-
24 larly and with a great deal of safety because of the
25 presence of the antibiotics.

26 We feel now there is a great need for
27 education both with the public and the medical schools
28 and among medical people to counteract that rather unfor-
29 tunate trend.

30 THE ACTING CHAIRMAN: You seem to



1 suggest that the trend could be reversing itself, that
2 while initially the impact of the drugs may have led
3 people to believe the problem was going to be solved,
4 now it has opened up new and wider fields. Assuming
5 that the number of candidates entering our medical
6 schools are overall reasonably sufficient at the moment,
7 although there is a question of how long that will
8 continue if the level is not stepped up, is it not in
9 the hands of the medical profession to encourage people
10 to go into this field?

11 DR. McNALLY: I think so, I think we
12 are a lot to blame ourselves with our teaching methods.
13 May I say another word? It would seem to me that if we
14 improve the quality and kind of our teaching and make
15 it more attractive; for instance, one of the things we
16 have fallen down on particularly is not having enough
17 research teaching in our specialty.

18 A medical student is so much attracted
19 to any specialty in which he is taught not only the
20 known principles but also if he is introduced to a
21 specialty that is very active and sees evidence of the
22 fact it is going forward and carrying out research,
23 the student is more likely to be attracted to that
24 specialty rather than to one that appears to be rather
25 stationary and unimaginative.

26 I think we ourselves have been at
27 fault and I think we must take steps to correct that
28 sort of thing.

29 THE ACTING CHAIRMAN: You refer to the
30 importance of early detection of deafness or hard of



1 hearing in children: have you any specific suggestions
2 as to how such a program could be undertaken?

3 DR. McNALLY: I would think one thing
4 " would be, you might say, diagnostic teams. I mention
5 that some of these conditions are quite multiple and
6 in most instances it is difficult, for instance, for
7 one medical man to make such a diagnosis in a child.

2 8 He would need the association of a
9 psychologist, possibly a neurologist, making up a team
10 to find out what the trouble is. This we could set up
11 in key areas, this type of diagnostic service that
12 would be available to the children and to schools much
13 more widely than we have at the present time.

14 THE ACTING CHAIRMAN: Under what
15 auspices?

16 DR. McNALLY: I would think it would
17 be under the hospitals attached to medical centres but
18 in certain specific instances that might have to be
19 even more widespread than that but it would be rather
20 difficult to envisage a rare ideal clinic that was not
21 attached to a teaching hospital.

22 THE ACTING CHAIRMAN: That brings me
23 to your statement that your suggestion is you have only
24 half as many practising otolaryngologists as recommended
25 by the American Academy and in the rural communities
26 the ratio is much less.

27 Is it feasible to believe that you
28 can improve that ratio in rural communities where in
29 view of the - I was going to say the impossibility but
30 then nothing is impossible, but the difficulty of



1 establishing proper facilities; can you picture a team
2 of neurologists and otolaryngologists and psychologists
3 established in rural communities?

4 DR. McNALLY: No sir, it would certainly
5 have to be a minimal-sized community. It might be
6 possible to have a diagnostic team go out on occasion
7 from a centre but they would have to be located in a
8 bigger centre, not in a teaching hospital. I do not
9 imagine we can set this type of thing up in too wide-
10 spread a manner; it would have to be of some type of
11 basis that might do a bit of travelling but certainly
12 more widely than we have now. There would be limits,
13 very definite limits.

14 THE ACTING CHAIRMAN: Thank you, Dr.
15 McNally. Dr. Van Wart?

/dpw

16 COMMISSIONER VAN WART: Dr. McNally,
17 in Section 23 you speak about the teaching hospitals
18 where post-graduate training of otolaryngology can be
19 obtained. Are these schools teaching the maximum number
20 at the present time, or can they take more students?

21 DR. McNALLY: You mean the maximum
22 number in otolaryngology, for instance?

23 COMMISSIONER VAN WART: Yes.

24 DR. McNALLY: I might answer in this
25 way, Dr. Van Wart, that they are not teaching the
26 maximum number of Canadians at the present time, and
27 I think it is fair to say that most of the clinics that
28 I know of now probably have a full complement of students,
29 but certainly in our own case, speaking for our own
30 hospital, they are not all Canadians, so that we are not



1 handling the number of Canadians actually that we could.

2 COMMISSIONER VAN WART: Are you refusing
3 Canadians admission?

4 DR. McNALLY: Well, unless they are
5 sub-standard, we are trying to take the best people
6 that apply, and we are not turning away good Canadians,
7 I can assure you.

8 COMMISSIONER VAN WART: Is it possible
9 to enlarge your facilities, so that you could handle
10 more otolaryngologists?

11 DR. McNALLY: I would think that the
12 existing facilities might be enlarged somewhat. I
13 would hope, Dr. Van Wart, that a greater source of
14 additional training would be to bring up some of the
15 allied hospitals to the point where they would have
16 staffs that could help with the teaching. I would hope
17 that that would be the greatest source. I think that
18 most of our teaching hospitals today are fairly well
19 staffed, but there are a number that with better quali-
20 fied people on them could take part in the teaching.

21 COMMISSIONER VAN WART: In other words,
22 you could enlarge your present facilities and not need
23 another school in the province to teach these?

24 DR. McNALLY: Well, Dr. Van Wart, we
25 have certainly suggested, for instance, another centre.
26 There are two centres here in Montreal, and we feel that
27 certainly Quebec should have a centre for teaching.

28 For instance, there is a new school
29 starting up now in Sherbrooke, and one could envisage
30 that at a later date a centre could be set up in



1 Sherbrooke, and as these other areas develop I would
2 hope that they would develop centres of teaching.

3 COMMISSIONER VAN WART: Turning to
4 Section 39(c) of your summary and recommendations or
5 rather 39(4)(3):

6 "Increased financial support for the
7 above."

8 What source of finance have you in mind?

9 DR. McNALLY: I was personally, and I
10 think I may speak for the Committee on that, I am not
11 sure that I can; we were thinking of a set-up somewhat
12 similar to the national institutes of health in Washington,
13 whereby trainee grants and fellowships are made available
14 to people who want to take better training, and to insti-
15 tutions that want to improve the quality of their teaching
16 staff.

17 I think it was along that line that
18 we were thinking in terms of.

19 COMMISSIONER VAN WART: The Government
20 setting up a scheme of financing?

21 DR. McNALLY: Yes sir, that would be
22 right.

23 COMMISSIONER VAN WART: That is the
24 Provincial Government?

25 DR. McNALLY: I would think probably
26 provincial and federal. In Washington I believe it is
27 on a federal basis.

28 COMMISSIONER GIRARD: You, Dr. McNally,
29 mentioned at the beginning of your statement that detec-
30 tion in schoolchildren of defects, that ascertain team



1 was required for school detection. Is the work done in
2 the schools; for example, in the Montreal schools, audio
3 meters, does this audio meter work help or is it suffi-
4 cient?

5 DR. MONTREUIL: No, it is very useful,
6 and it should be expanded everywhere. When a child has
7 a hearing defect this child could be sent to a diagnosis
8 centre where a team could carry on more thorough examina-
9 tions to ascertain the degree of deafness, and the
10 ideology of the symptoms, and also make appropriate
11 recommendations where surgical or medical intervention
12 is called for, or re-education is required. This would
13 work a great deal in carrying out detection even before
14 school age.

15 I think we could make a child a useful
16 participant in society, and also by educational means
17 the child could be prevented from being a public dependent.

18 COMMISSIONER GIRARD: All the benefits
19 that could be derived for the child particularly with
20 respect to early detection of such defects; I should
21 like to know in this respect what could your group do
22 in order to disseminate more widely the use of the audio
23 meter in Montreal?

24 Is the use of this instrument used in
25 the rural areas? What can be done to expand the use of
26 this instrument elsewhere in the province?

27 DR. McNALLY: I cannot say, but as we
28 stated, it is very important, because as you said most
29 of this work is done in the cities, and not in the
30 country areas. Perhaps it is our fault, because our



1 Society has not raised this particular question, and it
2 is a very important one.

3 COMMISSIONER GIRARD: In other words,
4 you cannot say whether or not an observation was brought
5 before the provincial Minister of Health, whether or not
6 such work was done in the rural schools?

7 DR. McNALLY: No, our Association made
8 no such representation. Perhaps such representations
9 were made individually with the Ministry of Health, but
10 our Association itself has done nothing of this kind.

11 COMMISSIONER BALTZAN: Dr. Montreuil
12 and Dr. McNally, following up on the previous questions,
13 am I right in concluding that as matters stand at the
14 present time, that you have adequate hospital accommoda-
15 tion, adequate equipment, and even adequate personnel
16 to take on more candidates to be trained as otolaryngolo-
17 gists, or are you short of any one of these things?

18 DR. McNALLY: I would say we are short
19 of all of them in some measure, because as we mention
20 here in the brief there are only two universities or
21 schools throughout Canada where, for instance, any
22 research or any investigation is being carried out, and
23 I can assure you, for my part, that getting a laboratory
24 together at the Royal Victoria Hospital has been quite
25 a problem, trying to get the equipment, and trying to
26 get the necessary things together, and we are far from
27 being in an ideal state at the present time, and it is
28 one of the things that we feel we must at least have
29 sympathetic consideration by the powers that be.

30 We have had some help from both

...and this particular question, and it
is a very important one.

COMMISSIONER STANLEY: In other words
you cannot say whether or not an operation was proper
before the Provincial Minister of Health, whether or not
such work was done in the mental schools?

DR. McNALLY: No, our law is different and
no such representation. Perhaps such representations
were made indirectly with the Ministry of Health, but
our Association itself has done nothing of this kind.

COMMISSIONER STANLEY: Dr. McNALLY
and Mr. McNALLY, following up on the previous question
and I might in concluding that as matters stand at the
present time, that you have a separate hospital for the
deaf, adequate equipment, and even adequate personnel
to take care of these candidates to be trained as school
teachers, or are you short of any one of these things?

DR. McNALLY: I would say we are short
of all of them in some measure, because as we mention
before in the report there are only two universities or
schools throughout Canada where, for instance, any
training in any investigation is being carried out, and
I am sure you, for my part, what getting a laboratory
to do the work of the Royal Victoria Hospital has been done
a great deal, trying to get the equipment, and trying to
get the people to train together, and we are far from
being in a ideal state at the present time, and it is
one of the things which we want to have done.



1 Provincial and Dominion Government, but not on a scale
2 that allows us, for instance, to set up organizations
3 that are in keeping with our competing schools, say,
4 across the border. We are very far behind them in
5 facilities.

6 COMMISSIONER BALTZAN: Have you been
7 in a position, for instance, to decline certain appli-
8 cants just because you simply cannot accommodate them,
9 you cannot process them?

10 DR. McNALLY: For instance, a person
11 who up till now has wanted to do research, we couldn't
12 accommodate him because we didn't have facilities.

13 COMMISSIONER BALTZAN: Yes, but that is
14 referring to a particular portion of the training program?

15 DR. McNALLY: Yes.

16 COMMISSIONER BALTZAN: Now, gentlemen,
17 you also speak of centres for the training of otolaryngolo-
18 gists, and you speak of the advisability of having a
19 centre in Quebec. Now, the centre isn't a total training
20 area. My question is, if departments were enlarged and
21 equipped in various general hospitals, otolaryngological
22 departments, would that help in training more people and
23 to process more and to qualify them?

24 DR. McNALLY: I think that we use the
25 word centre here but as you say, if any general teaching
26 hospital would enlarge its department of otolaryngology
27 to the point that it met the qualifications laid down
28 by the Royal College of Surgeons and the provincial
29 College, on the one hand; for instance, the basic
30 training for an otolaryngologist is a year's internship,



1 a year medicine or surgery, and three years otolaryngology.

2 The hospital that would prepare itself
3 to give that type of training would help very greatly.

4 As a matter of fact just since we came into this room
5 Dr. Montreuil tells me that two hospitals in Quebec
6 and one in Montreal have met the requirements of the
7 Hospital Accreditation Board, and that is a very definite
8 step forward.

9 COMMISSIONER BALTZAN: They could have
10 at least two years outside of a centre. They could
11 have perhaps one to three years in a department in a
12 general hospital, to acquire the full needs, then also
13 put in a certain length of time doing research, or
14 special programs in a centre?

15 DR. McNALLY: We have been trying to
16 make that kind of arrangement with some of the western
17 schools, where they have one or two years accredited,
18 then we would take their students for the second or
19 third year as the case would be, to complete their
20 training, hoping that we could contribute in that way
21 to the total Canadian effort.

2 22 COMMISSIONER BALTZAN: I don't want to
23 put any nasty questions, but there have not been enough
24 applicants in this specialty. Is there something not
25 sufficiently attractive enough for graduates to pick up
26 this specialty?

27 DR. McNALLY: Well, I tried to answer
28 that a little earlier by saying that my own feeling is
29 it is because of the rather unfavourable propaganda at
30 the time the antibiotics came in. I think we must



1 accept some of the blame ourselves. I feel that if our
2 own service had been of a higher calibre we would have
3 attracted people we otherwise missed.

4 One of the things I would like to
5 have, and I am about to have, is a research laboratory
6 to be opened in about a month or two, but we must also
7 have divisions of audiology and speech therapy but my
8 division has not been up to what it should be, and I am
9 sure that if we had these things we would have attracted
10 more men.

11 COMMISSIONER BALTZAN: In regard to
12 speech therapy first, does the otolaryngologist himself
13 participate actively, or is that chiefly performed by
14 trained technicians in various technical skills and
15 management of certain instruments?

16 DR. McNALLY: Well, it varies very
17 considerably. For instance, the otolaryngologist
18 himself must participate very actively in seeing the
19 person first, and making the diagnosis, and ensuring,
20 for instance, that there is no basic paralysis in that
21 larynx.

22 There is no tumour, there is no beginning
23 of ulceration, and he must decide that the cause of the
24 speech defect is not medical or surgical, but a matter
25 of the patient not using the voice box that he has to
26 the best of his ability.

27 Then he asks the speech therapist to
28 see the patient, and they consult and decide that this
29 is a matter of voice training, or he is not pitching
30 his voice in the right key.



1 Then the speech therapist takes over
2 in most cases and gives the lessons and exercise and
3 training, and eventually the patient comes back to the
4 medical man to see that things are going along, and
5 that this is the final result.

6 COMMISSIONER BALTZAN: So that you
7 will be requiring, in order to meet the great demands,
8 also a considerable amount of technical assistance, both
9 in the field of hearing and the field of speech?

10 DR. McNALLY: Yes sir.

11 COMMISSIONER BALTZAN: And that would
12 completely complement the present-day progress in oto-
13 laryngology?

14 DR. McNALLY: That is a very, very
15 important part in otolaryngology programs.

16 THE ACTING CHAIRMAN: Do you do any
17 work with the mute?

18 DR. McNALLY: Well, we do, from a
19 diagnostic point of view, but then once a diagnosis is
20 made, for instance, that this, say, a child or a person
21 is mute because they have not heard, and as you know, sir,
22 we only speak because we are imitating what we hear, and
23 if the person cannot hear, then he cannot imitate.

24 Then it is up to the medical profession
25 and to the teachers of the deaf to devise special tech-
26 niques whereby this child gets an appreciation of sound
27 and language other than through his ears, and that then
28 becomes the very old problem of teaching of the mute or
29 the deaf, and as you know sometimes it is complicated
30 by blindness, the Helen Keller type, and something



1 extraordinary happens sometimes, whereby very devoted
2 people can get across to this individual.

3 The medical profession has a very
4 important part to play, but certainly the teacher of
5 the deaf must be given tremendous credit for the
6 patience and perseverance and skills that they use,
7 but all these things should be under the supervision
8 of the medical profession, and in the best schools that
9 is how it is.

10 THE ACTING CHAIRMAN: Dr. Montreuil,
11 have you anything to add?

12 DR. MONTREUIL: It was our feeling that
13 these teaching centres should be on a university level.
14 It is at McGill and it will be at Laval in Quebec. It
15 is not yet here at the University of Montreal. We hope
16 to get it on a university level, but I think that is
17 very important.

18 THE ACTING CHAIRMAN: I may not have
19 understood you. What do you mean by the teaching
20 centres being at a university level?

21 DR. MONTREUIL: The teaching of otolaryn-
22 gology.

23 THE ACTING CHAIRMAN: I am afraid I am
24 being very stupid. ;I mean, can you train otolaryngolo-
25 gists, other than at a university level?

26 DR. MONTREUIL: It depends, sir. Certain
27 hospitals have a program that is recognized by the Royal
28 College, but it should be directed by the university,
29 the control of the program of study should be under
30 university jurisdiction.

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as how to do.

Have you anything to add?

DR. MONTAGNIER: It was our feeling that

these teaching centres should be on a university level.

It is at McGill and it will be at level in Quebec. It

is not yet here at the University of Montreal. We hope

to get to on a university level, but I think that is

very important.

THE ACTING CHAIRMAN: I may not have

mentioned you. What do you mean by the teaching

centres being at a university level?

DR. MONTAGNIER: The teaching of oblique

biology.

THE ACTING CHAIRMAN: I am afraid I am

being very stupid. It means, can you train oblique

genes, other than at a university level?

DR. MONTAGNIER: It depends, sir. Some

people have a program that is recognized by the Royal

Society, but it should be directed by the university.

The control of the program of study should be under

university jurisdiction.



1 THE ACTING CHAIRMAN: I see what you
2 mean. What you are saying is that the Royal College
3 today recognizes certain training centres that are not
4 in teaching hospitals?

5 DR. MONTREUIL: Yes, most of them are
6 affiliated to the universities, but some will not parti-
7 cipate actively in the university teaching program.

8 THE ACTING CHAIRMAN: I see. Well,
9 thank you very much, Dr. Montreuil and Dr. McNally. It
10 was very helpful to have you here this afternoon.

11 DR. McNALLY: Thank you very much for
12 seeing us, sir. We are quite impressed by the amount
13 of work you people appear to put into it before you see
14 us. It is very impressive.

15 THE ACTING CHAIRMAN: I think we will
16 take a ten-minute break now.

17

18 --- Short Recess

19

GG/PB/dpw

20 THE ACTING CHAIRMAN: We will come to
21 order. We are now going to hear from La Société de
22 Service Social aux Familles. I want to say, at the
23 outset, that Mr. Choquette and his associates are
24 appearing at the specific request of the Commission
25 this afternoon, and we appreciate them coming very much.

26 We indicated to Mr. Choquette that we
27 were interested in the resources that were available
28 for medical care and hospital services in the City of
29 Montreal for indigents and that other group who are not
30 at all times able to bear their own medical and other



1 health expenses and we asked him if he would come and
2 tell us something of the problems of these people :
3 encounter, in seeking this service and possibly give
4 us some actual case histories. Have you anything written,
5 Mr. Choquette?

6 MR. CHOQUETTE: Very little.

7 SUBMISSION OF LA SOCIÉTÉ DE SERVICE SOCIAL

8 AUX FAMILLES

9 Appearances: Jacques Alarie
10 Mr. E. Choquette
Mrs. P. Deschenes

11 THE ACTING CHAIRMAN: Well then, you
12 just proceed as you wish, and if you would introduce
13 your associates to us, and then call on them and you
14 just make your submission and we may interject from
15 time to time,

16 I hope we can first listen to you and
17 then we will ask the questions.

18 MR. CHOQUETTE: We have accepted with
19 pleasure your invitation to have us appear before you
20 and to provide you with our experience in medical
21 problems and services placed at the disposal of indigent
22 or others who earn their living but are not able to
23 assume responsibilities for medical care.

24 Without getting into these problems
25 I think it would be appropriate to identify ourselves.
26 This Society of Social Service to Families is an organiza-
27 tion for social family service as it exists as others
28 across our country. The nature of service dispensed
29 by our agencies varies as we cater to the family and
30 this agency constitutes the crossroads towards which

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us some actual case histories. Have you anything with

Appearance: Jaqueline Alarie

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on our families varies as we cater to the family and

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1 converge many kinds of problems which are encountered
2 every day in life.

3 The method of working for this family
4 agency that I represent is inspired by techniques of
5 social professional service. These techniques are
6 amplified by a group of services which are complementary
7 similar to those internal services in a hospital placed
8 at the disposition of practising doctors.

9 This agency which is the central
10 social family service, which is central social family
11 organization, French-Catholic of our region, exercises
12 its activities in a geographical territory determined
13 by the diocese of Montreal and this is some 45 municipi-
14 palities in addition to the City of Montreal.

15 We would like, at this moment, to bring
16 to the attention of your Commission that our evidence
17 does not constitute a brief which is to be presented
18 officially by the legal authorities of our agency, but
19 that the purpose of our appearing before this Commission
20 is none other than to enlighten you as to the services
21 we render and to bring to your attention in part observa-
22 tions by the internal administration of our organization
23 as brought to your attention previously.

24 For this reason we can testify that
25 though we render a minimum service to the majority of
26 the population since the existence of hospital insurance,
27 there still remains certain sectors of the population who
28 face problems of health and welfare and who require
29 urgent attention.

30 Multiple problems, family problems for



encourage many kinds of problems which are encountered every day in life.

The method of working for this family agency that I represent is inspired by techniques of social professional service. These techniques are amplified by a group of services which are complementary similar to those of a hospital placed at the disposition of practicing doctors.

This agency which is the central social family service, which is central social family organization, French-Catholic of our region, exercises its activities in a geographical territory determined by the diocese of Montreal and this is some 45 municipalities.

We would like, at this moment, to bring to the attention of your Commission that our evidence does not constitute a brief which is to be presented officially by the legal authorities of our agency, but that the purpose of our appearing before this Commission is none other than to enlighten you as to the services we render and to bring to your attention in such manner the interest administration of our organization as brought to your attention previously.

For this reason we can testify that the population since the existence of hospital has been there still remain certain sectors of the population with these problems of health and welfare and who require multiple problems, family problems for



1 which the services of our agency are requested there are
2 many that come directly from debts which render families
3 destitute and which we can qualify as family crises.

4 Among these debts we have observed the
5 greater ones are associated directly with the standards
6 of health of the family. Many cases consist of hospital
7 debts contracted previous to the existence of hospital
8 insurance. There are also some debts which were
9 incurred towards practising doctors in various categories.

10 We don't face these problems among the
11 persons who we identified previously as indigents
12 receiving public assistance. The explanation is simple:
13 there can be no hospital debts because a bill incurred
14 in hospital was paid for by the public assistance fund.
15 Also the doctors guided by the inquiry of the public
16 assistance group directly related to hospitalization
17 were informed of the economic capabilities of their
18 patients.

19 The cases which we get, the veritable
20 problems are those where the head of the family was
21 receiving a revenue and consequently ineligible for
22 public assistance, but who was so economically weak he
23 couldn't bring himself to face serious unforeseen
24 medical expenses. It is for this reason, today, having
25 obtained relief from hospitalization costs they must
26 again carry their old hospital and doctor debts which
27 would exceed often many thousands of dollars.

28 For all the situation has gradually
29 reached a better level; since the existence of hospital
30 insurance it is not better for those who are economically



1 weak insofar as it refers to medical or drug expenses.

2 For the indigents we are tempted to
3 affirm that the situation is worse since the existence
4 of hospital insurance. In this case the explanation is
5 as simple as referred to previously, and in all justice
6 to the medical profession we must be specific.

7 As I mentioned previously when our
8 public assistance inquiries indicated indigence the
9 doctors could lean on the source of the information and
10 in many cases as a charity have cancelled out many
11 medical bills.

12 However, since this sort of information
13 is no longer at their disposal because all the sick are
14 hospitalized on an equal basis the doctors are required
15 to develop a veritable system of administration in
16 addition to their regular practice in order to collect
17 these medical charges to which they are entitled.

18 Bills are sent out to patients. It is
19 brought to our attention that a great many indigent
20 patients or economically incapable receive doctors'
21 bills through the intermediary of a collection agency
22 and are panic-stricken and don't return to their doctor
23 to explain their present incapability of making payment.

24 Many go to loan companies to pay
25 their debts. Others neglect to pay certain other obliga-
26 tions such as rent, heat, electricity and so forth in
27 order to pay another bill on which pressure has been
28 placed by the collection agency.

29 From there develops total disorganization
30 of the family budget which inevitably drives this family

work insofar as it refers to medical or drug expenses.
For the indigents we are referred to

and in that the situation is worse than the existence
of hospital insurance. In this case the explanation is
as simple as referred to previously, and in all justice
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is no longer at their disposal because all the sick are
hospitalized on an equal basis the doctors are required
to develop a suitable system of administration in
addition to their regular practice in order to collect
these medical charges to which they are entitled.

Bills are sent out to patients. It is
difficult to pay attention that a great many indigents
patients or economically incapable receive doctors'
bills through the intermediary of a collection agency
and are unable to pay them and don't return to their doctors
to explain their present incapacity of making payment.
They go to loan companies to pay

their debts. Others neglect to pay certain other charges
such as rent, heat, electricity and so forth in
order to pay another bill on which pressure has been
placed by the collection agency.

From these developments total disaster
of the family budget which inevitably drives this family



1 towards the social agency who must face these situations
2 which have deteriorated, more or less, depending on the
3 time which has elapsed before demanding some help.

4 A large number of new interviews are
5 now forced on social agencies.

6 It is not that our agency refuses or
7 does not want to discharge its responsibilities to
8 complete its mission of help towards those who are
9 victims of troubles. However, in being realistic we
10 are worried that this state of things will increase.

11 As far as the situation forces us to
12 place more persons to solve this type of problem, of
13 budgetary rehabilitation, and more time, and once the
14 investigation is done it requires a solution for finan-
15 cial assistance which surpasses the means, objective
16 and initiative of private enterprises.

17 We wouldn't want these few remarks to
18 leave a doubt on the collaboration of the medical profes-
19 sion. We would like to affirm that we do obtain very
20 excellent collaboration from the doctors who don't hesi-
21 tate to reduce or even cancel out completely their
22 doctors' bills when we relate to them the situation of
23 certain families of their patients.

24 We don't believe that the wrong is
25 there, but we do, however, believe that the indigent
26 or the economically weak has not the means to keep up
27 his medical bills or other expenses directly related to
28 sickness. We believe equally there is insufficient or
29 total incapacity of these patients to pay their medical
30 expenses.

To this problem we must add and bring
to your attention the problem of buying pharmaceutical

towards the social agency who must face these situations
which have deteriorated, more or less, depending on the
time which has elapsed before demanding some help.

A large number of new interviews are

now forced on social agencies.

It is not that our agency refuses or

does not want to discharge its responsibilities to

complete the mission of help towards those who are

victims of troubles. However, in being realistic we

are worried that this state of things will increase.

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place more persons to solve this type of problem, of

budgetary rehabilitation, and more time, and once the

investigation is done it requires a solution for the m-

cial assistance which surpasses the means, objective

and initiative of private enterprises.

We wouldn't want these few remarks to

leave a doubt on the collaboration of the medical group

alone. We would like to affirm that we do obtain very

excellent collaboration from the doctors who don't feel

that we refuse or even cancel out completely their

doctor's bill when we relate to them the situation of

certain families of needy patients.

We don't believe that the wrong is

there, but we do, however, believe that the budget

on the economically weak has not the means to keep up

the medical bills or other expenses directly related to

illness. We believe equally there is insufficient or

total incapacity of these patients to pay their medical

To this problem we must add and say

to your attention the problem of paying pharmaceutical



1 products.

2 If we must rejoice that progress of
3 modern science in the matter of wider and better use of
4 pharmaceutical products we are obliged to realize that
5 miracle drugs are extremely expensive and that their
6 cost often is beyond the capacity of the economically
7 weak.

8 There are many families who manage to
9 balance their budget, more or less, but manage it just
10 up to the day that the family is struck by sickness.
11 Immediately these medical expenses are too heavy for
12 the family income.

13 From this fact we see a large number of
14 families that are declining towards economic chaos and
15 unfortunately pass through a social chaos cycle which
16 may bring about a rupture in family ties.

17 The consequences to this hardship are
18 many and varied and I do think that it would be futile
19 to enumerate these before persons who are so well
20 qualified to understand them.

21 For me, it would suffice to conclude
22 by stating that when economic insecurity adds itself to
23 physical hardship of a family the larger problems are
24 to be foreseen, and these are sometimes beyond the
2 25 immediate family, since these consequences may well
26 carry themselves and affect the future of the children
27 of the family.

28 As you have requested, Mr. Chairman,
29 I was accompanied by my colleagues who are at your
30 disposal to present to you a few cases, and together

If we must rejoice that progress of

modern science in the matter of wider and better use of
pharmaceutical products we are obliged to realize that
medicinal drugs are extremely expensive and that their
cost often is beyond the capacity of the economically
weak.

There are many families who manage to
relieve their budget, more or less, but manage it just
up to the day that the family is struck by sickness.
Immediately these medical expenses are too heavy for
the family income.

From this fact we see a large number of
families that are drifting towards economic chaos and
unfortunately pass through a social chaos cycle which
may bring about a rupture in family life.
The consequences to this hardship are
many and varied and I do think that it would be foolish
to underestimate these before persons who are so well
qualified to understand them.

For me, it would suffice to consider
the anxiety that when economic insecurity adds itself to
physical handicap of a family the larger problems are
to be foreseen, and these are sometimes beyond the
immediate family, since these consequences may well
carry themselves and affect the future of the nation
of the family.

As you have requested, Mr. Chairman,

I was accompanied by my colleagues who are all
directed to present to you a few copies, and together



1 we will endeavour to answer any questions that you may
2 wish insofar as we are competent to do so.

3 On my left is Madame Deschenes, who is
4 a social worker in our agency and on my right, Mr.
5 Jacques Alarie, who is a senior social worker with us.

6 THE ACTING CHAIRMAN: Thank you, Mr.
7 Choquette. Have either of your colleagues some case
8 histories they would like to put on the record now?
9 I think that might be helpful.

10 MME. DESCHENES: We have a case on here
11 of a family, including four children, including a three-
12 month old child, and the father earns \$64 a week, which
13 is an average salary for this category family in our
14 agency.

15 Since January, 1962, the family spent
16 for hospital bills and doctors' bills \$206. The monthly
17 income of the family, including family allowances for
18 children amounted to \$276. The minimum expenses, inclu-
19 ding rent, heat, amounted to \$298. Thus, nothing is
20 left to pay the doctors' fees and the hospital bills,
21 and, of course, these creditors are demanding their
22 money, and they have come to us, these people have
23 come to us for assistance.

24 Actually, we can't pay these bills for
25 them. We have had to contact the hospitals and ask them
26 to delay payment and explained the situation of the
27 family and occasionally good results have been forth-
28 coming.

29 The doctors have agreed to reduce pay-
30 ment or even to cancel the bills, but this same result



We will endeavour to answer any questions that you may wish to ask as we are competent to do so.

On my left is Madame Desroches, who is a social worker in our agency and on my right, Mr.

Madame Alarie, who is a senior social worker with us.

Chapelle, have either of your colleagues some cases histories they would like to put on the record now?

I think that might be helpful.

Mrs. Desroches: We have a case on hand

of a family, including four children, including a three year old child, and the father earns \$64 a week, which

is an average salary for this category family in our

since January, 1955, the family spent

for hospital bills and doctor's bills \$900. The monthly

income of the family, including family allowances for

children amounted to \$470. The minimum expenses, including

living costs, here, amounted to \$498. Thus, nothing is

left to pay the doctor's fees and the hospital bills,

and, of course, these children are demanding their

money, and they have come to us, these people have

come to us for assistance.

Actually, we don't pay these bills for

them. We have had to contact the hospital and ask them

to delay payment and explained the situation of the

family and occasionally good results have been found.

concern.

The doctors have agreed to reduce pay-

ment or even to cancel the bills, but this means we will



1 is not always obtained. It often happens that the
2 client is very anxious and worried and he is unable to
3 work normally. You can imagine the problems that arise
4 between two parents and also problems between parents
5 and children in such a situation.

6 There is another case in another family
7 which is similar to the latter. This family accumulated
8 during the year some \$3,000 in debts for furniture and
9 clothes. In 1957 the husband was made bankrupt in order
10 to avoid seizure of his personal belongings. This man
11 also earns \$65 a week.

12 The doctor bills amounted for 1961 to
13 \$890 and after studying the family's budget we saw that
14 the total revenue for the family was \$300. The expendi-
15 tures amounted to \$269 which leaves only about \$30, so
16 it means that \$1, each doctor receives about \$1 per week,
17 so it will be years before they are finally paid.

18 We still have another case, a family,
19 including six children, the oldest 6 years old and the
20 youngest is 18 months old and the mother has a great
21 deal to do in the house. Also she is sick. She suffers
22 from allergies and bronchitis. The doctor recommended
23 certain medicine which amounted to some \$40 per month.

24 This woman came into the agency because
25 she had no money to pay for the medicine so our agency
26 agreed to pay for two prescriptions that were given her
27 by the doctor. After having studied the debt of these
28 people, the debts they had for furniture and other things
29 we were able to plan, more or less, the account so that
30 the family, in future, would be in a position to obtain



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The doctor bills amounted for 1951 to \$500 and after studying the family's budget we saw that the total revenue for the family was \$300. The expenses amounted to \$500 which leaves only about \$30, so it means that \$1, each doctor receives about \$1 per week so it will be years before they are finally paid.

We still have another case, a family, including six children, the oldest 6 years old and the youngest is 18 months old and the mother has a great deal to do in the house. Also she is alone. The sufferer from diabetes and rheumatism. The doctor recommended certain medicine which amounted to some \$10 per month.

This woman came into the agency because she had no money to pay for the medicine so our agency agreed to pay for two prescriptions that were given her by the doctor. After having studied the case of these people, who have had for furniture and other things we were able to plan, more or less, the account so that the family, in future, would be in a position to obtain



1 the drugs necessary, but we can't continue such assis-
2 tance indefinitely in such cases so the mother must take
3 must substitute, withdraw money used for food to pay for
4 these medicines.

5 I have another family here. All these
6 cases are somewhat similar, but each one is a very
7 pitiful case, and each one presents a certain problem.

8 This is a family with two children.
9 The mother was operated on in November, 1961, and they
10 came to us for family assistance. We realized that
11 there was serious financial problems involved with this
12 family. The husband earns \$54 a week. This is very low.
13 The total income is \$264 and expenditures amount to
14 \$284 a month. He had accumulated hospital bills, doctor
15 bills, in the amount of some \$400, so then in addition
16 to all the other medical debts they have had to care for
17 the mother and for the children who have also been sick.

18 THE ACTING CHAIRMAN: Mr. Alarie, would
19 you have some cases?

20 MR. ALARIE: I do have some. The
21 following case will illustrate the situation of a family
22 which is a needy, so-called needy family. In other
23 words, the income of the family does not enable it to
24 obtain medical care it requires. The father is 37 years
25 old and he is a sweeper in a hospital. The mother is
26 25 years old and is awaiting her seventh child.

27 There are six children in the family,
28 four are school age; the oldest is 9 years of age.
29 That includes a salary of \$207 monthly plus \$36 a month
30 family allowance, so this makes a total of \$243 per



1 month or \$288.64. These expenses include only the
2 absolute minimum requirements of the family. The
3 monthly deficit in the budget is \$35.64.

4 " Naturally, this deficit is generally
5 compensated for by reduction in food expenditure with
6 the following - with the consequence that you can
7 imagine on health, the health problem of this family.

8 It is as follows: the mother came to us
9 through the hospital that she applied to because she had
10 serious anaemia and she was also unable to obtain the
11 necessary medicine required for her health care.

12 Furthermore, the diet prescribed by the
13 doctor cost an additional \$18 per month on the general
14 regular food, over her regular food budget.

15 We also observed that this client was
16 obliged to discontinue her visits to the dispensary
17 since these visits were useless as she was unable to
18 provide herself with the necessary drugs.

19 As to the health of the father, he
20 suffers from lumbago and he needs care for this also.
21 He is unable to obtain the necessary medicine. The
22 health of the children is bad because of malnutrition
23 and the problem of anaemia is a problem here also.

24 More specifically, one child suffers
25 from blindness. Another child has diabetes. Another
26 child has cardiac troubles and a third child has
27 pronounced, severe anaemia. The Children's Hospital
28 recommends, for these children, a diet, a more balanced
29 diet with vitamins.

30 The same hospital occasionally gives



month of \$268.64. These expenses include only the
absolute minimum requirements of the family. The
monthly deficit in the budget is \$35.64.
Normally, this deficit is generally
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doctor cost an additional \$18 per month on the general
regular food, over her regular food budget.
We also observed that this client was
obliged to discontinue her visits to the dispensary
since these visits were useless as she was unable to
provide herself with the necessary drugs.
As to the health of the father, he
suffers from impago and he needs care for this also.
He is unable to obtain the necessary medicine. The
mother of the children is bad because of malnutrition
and the problem of anemia is a problem here also.
More specifically, one child suffers
from diabetes. Another child has diabetes. Another
child has cardiac troubles and a third child has
pronounced, severe anemia. The Children's Hospital
recommends, for these children, a diet, a more balanced
The same hospital occasionally gives



1 vitamins in the form of tonic to these children.

2 The hospital sometimes can give a tonic
3 which can be used for 15 days, and then it must be
4 renewed. There is another problem in connection with
5 the health problem, namely, the lodging problem for
6 this family. This family lived in a three-room apart-
7 ment till the month of October. There were six children
8 and two adults living in three rooms. Since October,
9 1961, we have helped this family find more suitable
10 lodging in a six-room apartment. We paid the first
11 month's rent as well as the moving expenses.

12 In summary, this family can hardly
13 obtain the drugs prescribed by the doctor. It needs
14 special assistance.

I have here another case of another family, two adults and four children. The father works as a maintenance labourer at a salary of \$236 per month which gives a monthly income of \$264 including the family allowance.

20 The monthly expenses amount to \$269.65
21 per month including \$18 per month for drugs.

PMCH/dpw22 The mother has arthritis and she was
23 treated in a hospital dispensary but this treatment
24 had to be discontinued because of lack of money to
25 purchase the necessary drugs. In this family there is
26 a 16-year old child who has asthma and according to the
27 examination of the specialist this child requires some
28 \$50-worth of medicine per month.

29 This family, we, have observed, buys
30 only those absolutely necessary medicines, that is,



1 those medicines which involve an expense of about \$18
2 per month.

3 In the same family there is a four-year
4 old child who also has asthma and the doctor has
5 prescribed a special diet for him which also would involve
6 greater expenditure for their food.

7 In this same family we had to intervene
8 and ask the doctor to cancel his bill and he agreed to
9 do this but in view of the fact there were also legal
10 expenses involved in obtaining collection of these
11 bills and the lawyer concerned refused to cancel his
12 bill.

13 Another doctor who had treated the
14 same family also agreed to cancel his bill which amounted
15 to some \$75. In view of the fact that the children
16 suffer from asthma in this family they have had to have
17 the doctor visit them at their home when they had their
18 asthma attacks and at each of these visits of the doctor
19 injections had to be given and they, of course, had to
20 be paid for.

21 THE ACTING CHAIRMAN: Thank you very
22 much indeed. Miss Girard, would you like to ask some
23 questions?

24 COMMISSIONER GIRARD: Madame Deschenes,
25 in the first case you mentioned the family with four
26 children and with \$64 income per week and expenses of
27 hospitals and doctors of \$206 in January and \$260 monthly
28 income and a number of hospital and medical bills to pay;
29 in this figure of \$298 expenditure for hospitals and
30 doctor bills, what I would say to the hospital ---



those medicines which involve an expense of about \$18
per month.

In the same family there is a four-year
old child who also has asthma and the doctor has
prescribed a special diet for him which also would involve

In this same family we had to interview
and ask the doctor to cancel his bill and he agreed to
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expenses involved in obtaining collection of these
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same family also agreed to cancel his bill which amounted
to some \$75. In view of the fact that the children
suffer from asthma in this family they have had to have
the doctor visit them at their home when they had their
asthma attacks and at each of these visits of the doctor
injections had to be given and they, of course, had to
be paid for.

THE ACTING CHAIRMAN: Thank you very
much indeed. Miss Girard, would you like to ask some

In the first case you mentioned the family with four
children and with \$64 income per week and expenses of
hospitals and doctors of \$400 in January and \$250 more in
income and a number of hospital and medical bills to pay
in this figure of \$650 expenditure for hospitals and



1 MME. DESCHENES: I mentioned a figure
2 of \$299 as the minimum expenditure of the family inclu-
3 ding rent, food and so on but this does not include
4 hospitalization and medical fees. They would amount to
5 some \$200 medical fees only, not hospitalization.

6 COMMISSIONER GIRARD: I do not think
7 there are very many cases where there is much hospital
8 expense involved in view of the hospitalization insurance
9 prevailing and these children must be in the group which
10 receives free hospitalization because there is a certain
11 additional sum involved.

12 MR. ALARIE: Previously existing hospita-
13 lization fees cover this.

14 MME. DESCHENES: For the month of
15 February these bills covered anaesthesologist bills and
16 these are not included in the expenses included under
17 an insurance scheme.

18 COMMISSIONER GIRARD: Anaesthesologist
19 fees and doctors' fees and others are sometimes charged
20 and this happens, namely, that such bills are given over
21 to a credit agency, does that happen?

22 MME. DESCHENES: Yes.

23 COMMISSIONER GIRARD: We know the
24 exorbitant rates charged by loan companies; once a
25 credit company has taken over an account the client
26 goes to your Association and tells you about his debts,
27 and this debt, of course, is multiplied by the interest
28 accumulated and so forth. Are there any cases where,
29 when you bring this matter to the doctor or anaesthe-
30 logist; are there any cases where the doctor or



Mr. DEBOLLE: I mentioned a figure of \$299 as the minimum expenditure of the family in the way of rent, food and so on but this does not include hospitalization and medical fees. They would amount to some \$700 medical fees only, not hospitalization.

COMMISSIONER GIBBARD: I do not think there are very many cases where there is such hospitalization involved in view of the hospitalization insurance prevailing and these children must be in the group which receives such hospitalization because there is a certain

Mr. ALAN: Previously existing hospitalization fees cover this.

Mr. DEBOLLE: For the month of February these bills covered anesthesiologist bills and these are not included in the expenses included under an insurance scheme.

and this happens, namely, that such bills are given over to a credit agency, does that happen?

COMMISSIONER GIBBARD: We know the exorbitant rates charged by loan companies; once a credit company has taken over an account the client goes to your Association and tells you about his debts, and this debt, of course, is multiplied by the interest accumulated and so forth. Are there any cases where when you bring this matter to the doctor or anesthesiologist are there any cases where the doctor or



1 anaesthesiologist refuses to cancel the bill owing?

2 MME. DESCHENES: Yes, there are cases
3 where they refuse but in most cases the client himself
4 will not take any steps to reduce or to have the bill
5 cancelled.

6 He has to go through an agency and we
7 take the initiative with the consent of the client, of
8 course, to contact either the doctor directly who very
9 often is not aware of the material situation of his
10 patient.

11 COMMISSIONER GIRARD: But generally
12 speaking it is the doctor or the anaesthesiologist, they
13 cancel the bill?

14 MME. DESCHENES: Well, we cannot say
15 as a general rule that they cancel but sometimes we
16 are lucky, sometimes we are able to have it cancelled
17 or reduced or sometimes, when the situation is more
18 favourable, the bill is reduced.

19 However, this does not apply to all
20 cases, there are certain visits to the home and patient
21 which must be paid for and there are certain medical
22 costs to the Association.

23 COMMISSIONER GIRARD: Well, when they
24 go to a finance company it is impossible to cancel the
25 bill because then it is too late because the client did
26 not previously take any steps to notify the doctor that
27 the client was unable to pay his bill.

28 MR. CHOQUETTE: Yes. For instance,
29 a finance company cannot take the initiative to cancel
30 the bill but this is simply a business matter between



2. MR. DISCHOW: Yes, there are cases
3. where they refuse but in most cases the client himself
4. will not take any steps to reduce or to have the bill
5. cancelled.

6. He has to go through an agency and we
7. take the initiative with the consent of the client, of
8. course, to the fact either the doctor directly who very
9. often is not aware of the material situation of his
10. patient.

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1 the doctor and the finance company. The finance company
2 does not want to give up a client for the collection
3 agency has a commission so we have no luck with the
4 collection agency. Sometimes we obtain partially
5 favourable results when we go and talk to the doctor
6 but the problem is complicated when there are legal
7 costs involved; these legal costs are adding to the
8 client's costs.

9 COMMISSIONER GIRARD: Could you say
10 when this bill is not given to a collection agency and
11 you take it to the doctor, can you say the doctor
12 generally cancels?

13 MR. CHOQUETTE: I would say very often
14 the doctors have co-operated with us but the doctors
15 have shown a great deal of generosity. I do not want
16 to specify which doctors do not cancel but generally
17 speaking doctors co-operate with us.

18 COMMISSIONER GIRARD: In almost every
19 case mentioned here you told us of cases where the
20 patients had a rather high bill for drugs and in several
21 cases you stated in order to pay for these drugs families
22 had to do without essential food.

23 Since you are a social worker and since
24 you are familiar with family budgetary questions, must
25 this money always be deducted from the food budget or
26 could it not be deducted from other elements of the
27 budget?

28 For instance, the case of the family
29 who had a debt of \$3,000 but these debts involved
30 furniture and other things so you always say that the

the doctor and the finance company. The finance company
does not want to give up a client for the collection
agency has a commission so we have no deal with the
collection agency. Sometimes we obtain partially
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In instance, the case of the family



1 family had to reduce its food budget in order to pay for
2 drugs or medicine.

3 Is this always the case or are there
4 not other expenses which could be reduced in order to
5 pay for the drugs?.

6 MR. CHOQUETTE: Well, we are not the
7 ones who advise them to deduct from their food budget
8 to pay the drugs.

9 MR. CHOQUETTE: Well, we are not the
10 ones who advise them to deduct from their food budget
11 to pay for the drugs. The people come to us after the
12 evil has been done, they think it is the easiest way -
13 to deduct from the food. First, they reduce the quality
14 of the food they eat and thereafter they reduce the
15 quantity of the food they eat and that evil has already
16 been done.

17 We have a nutritionist expert in our
18 agency and this specialist recognizes the first step
19 to be taken but certain detrimental consequences result
20 from such a reduction in the food budget. There is a
21 certain disproportion right here in the fees paid for
22 drugs and expenditure for food.

23 COMMISSIONER GIRARD: Could you say in
24 most cases where there is an unbalanced budget, are
25 these cases generally due to illness or due to medical
26 expenses or similar expenses?

27 MR. CHOQUETTE: Well, in present condi-
28 tions this is a result of something that has already
29 happened in the past. As I already stated, people come
30 to us burdened with debt and they can undertake nothing

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to us laden with debt and they can undertake nothing



1 because they have a tremendous hospitalization bill to
2 pay and they do not have the money to pay their current
3 expenses. As a rule, the problem of debts plays a very
4 important role because the food problem is complicating
5 the situation.

6 COMMISSIONER GIRARD: There is also
7 the hospital bill?

8 MR. CHOQUETTE: You must bear in mind
9 not all patients are hospitalized as soon as possible
10 because the doctor requires patients to go to the out-
11 patient clinic before they can be admitted to the hospital.

12 Each section of the out-patient clinic
13 must be paid first before the hospital bill is paid.
14 Each time a fee of 25¢ can be charged for small items
15 in different departments but these small items add to
16 a very important sum.

17 COMMISSIONER GIRARD: If the out-patient
18 bills were paid for by government funds and if the
19 insurance were extended to include out-patient clinics
20 would this improve the situation for your clients?

21 MR. CHOQUETTE: I am not able to
22 answer that question. I might have some suggestions
23 but I am not prepared to submit them now. I also parti-
24 cipated in a Committee which submitted a rather volumi-
25 nous brief on this subject.

26 COMMISSIONER GIRARD: Let us examine
27 the matter from another standpoint; if there was no
28 reduction in fees for your clients would it be possible
29 to give your clients easier access to medical care?

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not all patients are hospitalized as soon as possible because the doctor requires patients to go to the out-patient clinic before they can be admitted to the hospital. Each section of the out-patient clinic

must be paid first before the hospital bill is paid. Each time a fee of \$50 can be charged for small items in different departments but these small items are not a very important sum.

COMMISSIONER GIRARD: If the out-patient

bills were paid for by government funds and if the hospitals were extended to include out-patient clinics would this improve the situation for your clients?

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COMMISSIONER GIRARD: Let us examine

the matter from another standpoint; if there was no reduction in fees for your clients wouldn't it be possible to give your clients easier access to medical care?

MR. CHOUETTE: Well, I would like



1 certain formula occurs, when I suffer from toothache
2 I have pain and I do not preoccupy myself with how I
3 am going to pay for the medical care. This is a matter
4 involving the human standpoint and our primary concern
5 is the human element.

2 6 ~~Q. Now, Mr. Commissioner Girard:~~ COMMISSIONER GIRARD: Could you tell
7 me whether there are many cases in Montreal in which
8 the family is unable to pay for medical care?

9 ~~A. Yes, Mr. Commissioner.~~ MR. CHOQUETTE: Well, if we take the
10 Dominion statistics and we show the average and compare
11 this with the cost of living we must realize that most
12 of our fellow citizens are in the needy category and
13 are not able to pay for the result of an accident or
14 illness.

15 ~~Q. Even if we say that the leading cases~~
16 constitute the minority of the cases there are still a
17 number of people unable to balance their budget.

18 COMMISSIONER GIRARD: On the question
19 of money, do you recall many cases where patients were
20 unable to receive care aside from the monetary question?

21 ~~Q. Does it happen frequently that there~~
22 are people who need or require medical care and do not
23 receive it?

I/AG/dpw 24 MR. CHOQUETTE: Well, that is where
25 people have received prescriptions. They have received
26 treatment and were unable to pay for it afterwards. We
27 don't know the exact percentage of people who have such
28 a problem in the City of Montreal, but there are many
29 such cases we are sure, but we don't know the exact
30 figures.



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and cases to the same, but we don't know the exact



1 MR. ALARIE: I feel it is important to
2 make a distinction between medical care that is required
3 perhaps once or twice a year, and which calls for
4 immediate expenditure which can unbalance the budget,
5 and chronic illness which, once diagnosed, requires a
6 good deal of time for treatment and may extend over two
7 or three years, and generally require certain medical
8 expenditures, considerable expenditures, which the family
9 cannot include in its budget as a regular expense without
10 making a deduction from another item.

11 COMMISSIONER GIRARD: Mr. Choquette,
12 what would you suggest to remedy this situation?

13 MR. CHOQUETTE: Well again, as I said
14 earlier, I didn't come here provided with, or prepared
15 to answer such questions. The Chairman had asked for
16 concrete examples. I haven't prepared any brief on
17 that specific point.

18 COMMISSIONER GIRARD: Of course, the
19 cases are all similar, so that the questions I have put
20 regarding one case are more or less the same as would
21 apply to other cases.

22 Well, I thank you; I think I needn't
23 push it further.

24 COMMISSIONER BALTZAN: Just one thing,
25 Mr. Choquette. It is getting very late, and you have
26 cited many sad stories, and all of which are true, and
27 unfortunately it makes a very poor kind of an ending for
28 us this afternoon.

29 Am I correct if I summarize it this
30 way, that the people you are talking about are the



1 people who are living from hand-to-mouth, as it were?

2 MR. CHOQUETTE: Yes.

3 COMMISSIONER BALTZAN: And if they had
4 not this sickness, they wouldn't be coming to you, and
5 you wouldn't have all these troubles. Therefore, on a
6 broad scale, if they earned more, or had more, or were
7 better provided, they would be able to look after them-
8 selves, so that consequently, and not to be facetious
9 or frivolous, the best medicine they can have to meet
10 these shortcomings is a little more money?

11 MR. CHOQUETTE: Probably.

12 COMMISSIONER BALTZAN: Because when they
13 are in need they can get the help medically in the
14 hospital way and in other ways, but it puts them back
15 economically going into debt and bankruptcy and psycholo-
16 gical disturbances. Am I right in that sort of a quick
17 summary?

18 MR. CHOQUETTE: I think you are right,
19 because these people represent the large group of the
20 average wage-earner without provision.

21 THE ACTING CHAIRMAN: Mr. Choquette,
22 we are very much indebted to you and your colleagues
23 for coming here this afternoon. I think Miss Girard
24 has pretty well covered the field in the questions she
25 has put to you.

26 It may be that the suggestion I am
27 going to make may not be appropriate, but I noted one
28 case, and there may have been others, where the minimum
29 expenses, it was the first one I think, that Madame
30 Deschenes quoted, where what were described as the

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for coming here this afternoon. I think Miss Givens
has pretty well covered the field in the questions and
and put to you.

It may be that the suggestion I am
going to make may not be appropriate, but I noted one
case, and there may have been others, where the minimum
expenses, it was the first one I think, that I have
not mentioned, where what were described as the



1 minimum expenditures, excluding bills for health care,
2 exceeded the family income. This is a theoretical
3 question. I would like to put it to you.

4 Supposing all these people in all these
5 cases that you have mentioned had their doctors' bills
6 paid, their hospital bills paid in the past, or their
7 out-patient bills paid today; you understand, of course,
8 that under the Hospital Insurance Act, it is for the
9 Province of Quebec to decide whether or not they pay
10 the out-patient bills.

11 The provision is there as far as the
12 Federal Government is concerned. And their drugs, all
13 these things are paid. What percentage of these families
14 would still be on your doorstep? How many of them are
15 what the social worker describes as the problem family?

16 MR. CHOQUETTE: I am sorry, Mr. Chairman,
17 I am not prepared to answer this in figures. I am
18 inclined to believe that the majority of those with a
19 little earning would be free from such worries. There
20 remains those that are indigents and probably do not
21 receive an adequate security income, but I think for
22 those wage-earners the majority of them would be
23 covered.

24 THE ACTING CHAIRMAN: You don't think
25 you are dealing to a considerable extent with a small
26 group of the population, who are really inadequate to
27 get along in this world no matter what support they have?

28 MR. CHOQUETTE: Well, at one time our
29 agency was dealing mostly with indigents. Nowadays,
30 like most social work agencies, we receive all kinds of



1 people, and we receive a greater and greater number of
2 people who are not indigents, who usually are not indi-
3 gents. They are just tight in their income and expendi-
4 tures, and then as soon as anything happens they become
5 indigents in a certain way, and most of the time this
6 has started with an illness.

7 So we figure something has to be done.
8 I don't know by what means, or who shall perform the
9 miracle, but we realize that the number is growing, and
10 something shall be done to cover this low income group.

11 THE ACTING CHAIRMAN: Are many of them
12 in your experience covered by insurance provided by
13 their employers?

14 MR. CHOQUETTE: I couldn't tell. It
15 would take some research in the files in the office
16 to know such a figure.

17 THE ACTING CHAIRMAN: Well, we quite
18 appreciate that you didn't come here to make any recommen-
19 dations to us. You came here to give us information,
20 and we are most obliged to you, and we are sorry we
21 have kept you so late. Thank you very much.

22 We are now going to hear from the
23 Children's Service Centre, and as in the case of the
24 preceding group, Mrs. McCrea and her associates are
25 appearing here at the request of the Commission, to
26 educate the members of the Commission, and if they care
27 to make any suggestions to us, but we recognize that
28 you are not presenting a formal brief but I believe you
29 have a written submission that you would like to read,
30 Mrs. McCrea?



SUBMISSION OF THE CHILDREN'S SERVICE CENTRE,
M O N T R E A L.

Appearances: Miss Margaret Forbes
Mrs. Muriel McCrea
Miss Eleanor Furlong

MRS. McCREA: A. AGENCY FUNCTION

Our Agency works with two groups of people.

1. Children, 2248 of them, who have to live away from their own homes because of illness of one or both parents; illegitimacy; separation; marital discord; desertion or neglect. These children live in foster homes spread over the Province of Quebec.

2. Unmarried Mothers (approximately 500 of them) who need help in planning for their future and the future of their children.

B. FINANCIAL STATUS OF CLIENTS

95% of these children are "indigent" and their basic needs of food, clothing and shelter are financed by the Quebec Public Charities Act. These funds do not cover medical care.

C. PRESENT MEDICAL SERVICE

Preventive - Our Agency runs paediatric clinics within the Agency (six per week) for regular preventive medical check-ups. This is financed through United Red Feather Services. Inoculations, etc., are given here.

Therapy - When a child is seen to have

Appointees: Miss Margaret Forbes
Mrs. Muriel McGee

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preventive - Our Agency runs pediatric

preventive medical check-ups. This is financed through
United Red Cross Services, Incubators, etc., are
given here.

therapy - When a child is seen to have



1 a special medical problem, e.g. eyes, heart, neurolo-
2 gical, or orthopaedic, he is referred to the Montreal
3 Children's Hospital who so far have given us all our
4 out-patient clinic service free. We sense a change in
5 attitude regarding continuation of this service to us.

6 D. PROBLEMS RELATED TO MEDICAL CARE OF INDIGENT CHILDREN

7 1. Dental Services - Although we have
8 some 2248 children a year to care for we have practically
9 no dental services. United Red Feather Services finance
10 a small clinic which covers emergencies but we have no
11 facilities for regular dental care for our children.
12 We could set up dental services within our own building
13 if we could get funds.

14 Further, there are no provisions for
15 dental plates or for orthodonture which can affect both
16 nutrition and emotional adjustment.

17 Notes on Problems in the Provision of
18 Medical Services to Indigent Clients of
19 Children's Service Centre, Montreal

20 2. Out-patient Services

21 a. In Montreal, For our wards living
22 in Montreal we use the Montreal Chil-
23 dren's Hospital and until hospitalization
24 they never made any demand on us for
25 payment.

26 However, this attitude seems to be
27 changing. E.G. Our psychiatrists have
28 always referred our emotionally
29 disturbed children for E.E.G. as a
30 diagnostic tool to rule out brain

about, or orthopedic, he is referred to the Hospital
Children's Hospital who so far have given us all the
out-patient clinic services there. We have a change in
attitude regarding consideration of this service to be
to the Hospital.

I Dental Services - Although we have
some 2246 children a year to care for we have only
no dental services. United Red Cross has given them
a small clinic which covers emergencies but we have no
facility for regular dental care for our children.
We could set up dental services within our own building
if we could get funds.

Further, there are no provisions for
dental plates or for orthodontics which can affect
nutrition and emotional adjustment.

Notes on Problems in the World War II
Medical Services to Infant Children of

a. It is obvious, from our words having
in Montreal we are the Hospital for
dental services and well hospitalization
they have made no very demand on us for
payment.
However, this attitude seems to be

always retained, our emotionally
disturbed children for P.D.G. as a
diagnostic tool to rule out



1 damage as the source of the problem.

2 The hospital is now asking that we pay
3 \$30.00 for this examination or that the
4 parents pay. As we have no funds for
5 this and as our children are indigent
6 it would seem that some adjustment will
7 have to be made or we will be handi-
8 capped in our therapy with these very
9 disturbed children.

10 b. Out-of-Town. Emergencies in rural
11 districts have to be handled by small
12 local hospitals in the district. We
13 receive bills for these services which
14 we have no funds to pay.

15 3. Medicines - Although the Montreal
16 Children's Hospital gives clinic services and drugs when
17 the child is at clinic or in hospital repeat orders of
18 drugs which have to be continued to control the patient's
19 condition must be purchased from commercial drugstores.
20 There are no funds for medication prescribed and often
21 treatment falls down because drugs cannot be secured.

22 4. Ambulance - We are always charged
23 for ambulance fees required by a non-ambulatory patient.
24 This is often absolutely necessary, e.g. when an infant
25 was transferred from Catherine Booth Hospital to the
26 Neurological Hospital for an emergency operation. There
27 are no funds for such provision for the indigent.

28 E. PROBLEMS RELATED TO WORK WITH UNMARRIED MOTHERS

29 When a girl finds herself illegitimately
30 pregnant she almost always seeks out some way of hiding



damage as the source of the problem.
The hospital is now asking that we pay
\$30.00 for this examination or that the
parents pay. As we have no funds for
this and as our children are indigent
it would seem that some adjustment should
have to be made or we will be forced to
stop our therapy with these very
distressed children. Furthermore, in many
instances, none of us handled by small
local hospitals in the district. We
receive bills for these services which
we have no funds to pay.

3. Medicine - Although the hospital
Oklahoma's Hospital gives clinic services and drugs which
the child or in clinic or in hospital repeat orders of
drugs which have to be continued to control the patient's
condition must be purchased from commercial drugstores.
There are no funds for medication prescribed and often
treatment falls down because drugs cannot be secured.

4. Anesthesia - We are always charged
for anesthesia fees reported by a non-ambulatory patient
This is often absolutely necessary, e.g. when an infant
was transferred from Garfield County Hospital to the
Neurological Hospital for an emergency operation. There
are no funds for such operation for the indigent.

5. Problems Related to Work with Unemployed Mothers
When a girl finds herself illegitimately
pregnant and almost always seems out some way of doing



1 her mistake from family and friends. She moves to
2 another city. Recognizing this fact the Child Welfare
3 League of America recommends that no residence restric-
4 tions be applied to Unmarried Mothers because if they
5 are refused service by a responsible agency they may turn
6 to more drastic solutions such as abortion or the black
7 market. They will not return home.

8 In Quebec we have always been proud of
9 our resources for working with Unmarried Mothers because
10 we have been able to serve them regardless of residence.

11 Since Hospitalization we have encountered
12 problems. Local hospitals differ in their procedure but
13 tend to refuse pre-natal care and are hesitant in fact to
14 accept non-residents.

15 There needs to be clearance nationally
16 on this problem because failure to provide service at
17 this time can result in physical and emotional damage
18 to both mother and child.

19 Thank you, Mr. Chairman and members of
20 the Commission. It seems particularly fitting that we
21 follow Mr. Choquette, because we pick up the wreckage
22 that his agency cannot save.

23 We have the children who are with us
24 because their home situations have completely broken up,
25 and the largest single reason for admission to care is
26 illness of the parents, either physical or mental.

27 There are the other reasons I have
28 listed on the summary. That is the first group. Those
29 are the children from family groups, and then we have
30 a very large group of unmarried mothers we work with,

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on this problem because failure to provide services at
this time can result in physical and emotional damage
to both mother and child.

Thank you, Mr. Chairman and members of
the Commission. It seems particularly fitting that on
Friday Mr. Gosselin, because we pick up the wreaths
that his agency sends every year.

We have one child who was with us
because their home situation have completely broken up
and the largest single reason for adoption is because of
illness of the parent, either physical or mental.
There are the other reasons I have

listed on the summary. That is the first group. These
are the children from family groups, and then we have
a very large group of unmarried mothers we work with.



1 where the presenting problem is from the very beginning
2 a medical problem, and has to be started that way.

3 95% of the children are on welfare
4 funds. They are committed to us by the social welfare
5 court because of neglect and inadequacy in their
6 families, and the Province of Quebec pays two-thirds
7 of the cost of the basic maintenance of these children.
8 This is food, clothing and shelter.

9 Red Feather funds pay one-third, and
10 there is no money paid from any source for medical care
11 for these children.

12 At present in the agency we have the
13 medical services that I have listed to you. We have a
14 preventive health clinic operated right within the
15 agency, because when you pick up the wreckage that Mr.
16 Choquette described the physical condition of the
17 children coming into care is pretty desperate.

18 We have all the way from just sort of
19 general poor parental care to situations like those that
20 came in last week, with six children who were infected
21 from rat bites, from the dreadful conditions that they
22 come in in, and medical care is an absolute must.

23 These children we take in have to be
24 cared for in other people's homes, and foster families
25 which we use are not prepared to take in children whose
26 health is a hazard to their own family life.

27 The only way we can get responsible,
28 adequate foster homes is to guarantee the children we
29 are placing there are going to have adequate medical
30 care.

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The only way we can get responsible
adoption is to get the children who
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1 In addition to our preventive clinics,
2 which are paid for out of Red Feather funds entirely,
3 we get our specialized medical services from the hospitals
4 and the out-patient departments have been very generous
5 with us.

2 6 We place about 500 children for adoption
7 and some of these children, when they are born, have
8 minor handicaps and need careful evaluation. We find
9 that the doctors at the Children's Hospital particularly
10 are very willing to evaluate the children and give us
11 complete medical assessments.

12 I think there is a change occurring
13 since hospitalization, that the hospitals are more pay-
14 ment-conscious than they were before hospitalization
15 occurred. We have two types of problems. One is the
16 problem of non-existent service, and the other is the
17 problem of the service we need and cannot pay for.

18 One of what I call the non-existent,
19 although that is not entirely true, is the dental
20 services to the children we have. We take them into
21 care. The foster families we put them with are pretty
22 responsible people, and they have regular dental care
23 for their children.

24 It is recommended by the doctors who
25 work in our preventive clinic that we do not have dental
26 services for our children except on an emergency basis.
27 Then when we do run into emergency dental care and there
28 is any need for any kind of equipment, whatever you
29 call dentures and orthodontures, and this sort of thing.
30 These are very expensive, and it is just practically



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1 impossible to get this, so that is our first --- we have
2 a recommendation that we would like to make there. I
3 think it is very apparent to us, because we handle two
4 different kinds of children.

5 The local Montreal residents, and get
6 for them financial help only in the area of the basic
7 necessities of food, clothing and shelter. We handle
8 the children from the Department of Northern Affairs,
9 and apparently that Department is financed so that we
10 can provide all the medical needs of the children.

11 If we give dental care we may pay it.
12 If we give medicines we may pay for them, if we need
13 ambulances, medical care of any kind, we may buy it.

14 This is available to the Eskimo child,
15 the Indian child, but not to the Montreal resident.

16 THE ACTING CHAIRMAN: That, I suppose,
17 is at the choice of the Province of Quebec and the City
18 of Montreal?

19 MRS. MCCREA: I don't know that, sir.

20 THE ACTING CHAIRMAN: You said the
21 province paid two-thirds of the basic cost. It could
22 pay more if it wished, I suppose?

23 MRS. MCCREA: I suppose. This comes
24 from the Welfare Department. It could be a gap between
25 two departments. The out-patient service for our wards
26 living in Montreal is adequate, and really quite wonder-
27 ful except on one level. We deal with a great many
28 emotionally disturbed children.

29 When they come from these homes that
30 have failed to respond to any kind of supporting treatment

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1 we have one institution that works with these most
2 disturbed children, trying to straighten them out again,
3 and one of the tools that the psychiatrists and paedia-
4 tricians wish to use is an electroencephalogram, because
5 they want to rule out brain damage as one of the reasons
6 for emotional disturbance.

7 They don't want to go on the basis that
8 it is environmental if there is actually physical brain
9 damage. Hospitals used to provide electroencephalograms
10 free. They are now asking \$30 per child. This means
11 we will not be able to do this step in the care of
12 children, because we haven't funds to pay for electroen-
13 cephalograms.

14 The second problem in out-patient
15 service is that we use foster homes, and that is wherever
16 good English-speaking Protestant families can be found,
17 and these are all over the province in pockets. So
18 some would be in Huntingdon, and some in Terrebonne.

19 For medical care we bring them back to
20 Montreal, to our own clinic and the Children's Hospital.
21 We run into the problem there of the small hospital that
22 demands payment, and again we have no resource for
23 payment of the small hospital bill on the outskirts.

24 THE ACTING CHAIRMAN: You are talking
25 about the out-patient bill?

26 MRS. McCREA: Yes, we have no trouble
27 whatever because the province accepts in-patient care.
28 We have the problem of medicines that everyone else has.
29 The medicines seem to be getting more expensive than
30 ever, and I even had a personal experience in which I

we have one institution that works with these most
disturbed children, trying to straighten them out again
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it is environmental if there is actually physical brain
damage. Hospitals used to provide electroencephalograms
free. They are now asking \$50 per child. This means
we will not be able to do this step in the care of
children, because we haven't funds to pay for electroencephalograms.

The second problem in our patient
services is that we use foster homes, and that in some
and these are all over the province in pockets. We
some would be in Hamilton, and some in Toronto.

For medical care we bring them back to
Hospitals, to our own clinic and the children's hospital.
We run into the problem here of the small hospital that
cannot pay, and again we have no resource for
payment of the small hospital bill on our own.

THE ACTING CHAIRMAN: You are talking
about the out-patient bill?

MRS. KERR: Yes, we have no trouble
whatever because the province accepts in-patient care.
We have no problem of medicines that everyone else has
the medicines seem to be getting more expensive than
ever, and I even had a personal experience in which I



1 suddenly became very well when I found out how expensive
2 the medication which was prescribed for me was going to
3 be and this becomes a real problem in an agency like
4 ours.

5 As long as the child is in hospital
6 medication is provided. When he comes outside into
7 the community and has to continue the medication to
8 control his condition, the cost of medical supplies is
9 a real problem to an agency like ours.

10 Ambulance services; I suppose everybody
11 has referred to you; the problem of getting patients,
12 non-ambulant patients, transported from one place to
13 the other.

14 The other group of people we have to
15 deal with all the time, and that are a very serious
16 medical problem to us at this point and everywhere
17 before, are unmarried mothers.

/PB/dpw 18 The story of the unmarried mother; if she
19 is a girl with any pride or capacity for rehabilitation
20 at all is when she finds that she is illegitimately
21 pregnant she tries to get as far away from home as
22 possible.

23 As far back as social work has been
24 done unmarried mothers were always found in another
25 city than the one in which they lived. The Child
26 Welfare League of America say arrangements should be
27 set up so that the mother can be treated in the location
28 in which she presents herself. We have been very proud
29 that in Quebec, Quebec was the first province in which
30 this was always possible.



1 It has never been a problem until
2 hospitalization. Now everybody is on their dignity
3 about who owes the hospital a bill. Some of the
4 hospitals are unwilling to accept the girl for service.
5 Others of them will accept if they get repayment.

6 One province will repay if the person
7 has been a member of the hospitalization in their province.
8 Another province won't pay at all. This really is a
9 very serious problem in working with the unmarried
10 mother because unless she is worked with by a responsible
11 agency she is open to the abortionist and the black
12 market. She does irreparable damage to her personal
13 problems and her physical health and God knows what
14 happens to the baby.

15 We are very concerned. In some way
16 there should be an inter-provincial arrangement to
17 cover this group of girls. I don't think we have any
18 other problem. We have only two brief illustrations
19 that are typical of what goes on, and they are very
20 simple. Perhaps you don't want to hear them?

21 THE ACTING CHAIRMAN: We would like to
22 hear them.

23 MRS. MCCREA: On my left is Miss
24 Furlong who is in charge of the work with unmarried
25 mothers. She will tell you a typical case of an
26 unmarried mother and the problem she presented. On my
27 right is Miss Margaret Forbes who is Director of Health
28 Services and the Children's Service school and will
29 illustrate by a very simple story the kind of out-patient
30 problems in small hospitals.



1 MISS FURLONG: Carol was an 18-year
2 old who came to Montreal from Ottawa, Ontario, on June
3 1st, 1961, hoping to make arrangements to have here
4 illegitimate child in one of the Montreal hospitals.

5 Carol was expecting her baby on or
6 about August 5th, 1961, and hoped, in coming to Montreal,
7 she could keep her condition from relatives, friends, etc.
8 As with many other unmarried mothers, Carol was unable
9 to share her problem with anyone prior to coming here.
10 That is with friends, with social agencies, in her city.

11 Her only thought was to leave home, to
12 hide herself and she suddenly arrived in Montreal without
13 any plans as to how she was going to manage, where she
14 was going to stay or what she was actually going to do.

15 While in Ottawa Carol worked as a
16 domestic but as her condition became apparent she had
17 to leave her job. Her savings were spent to maintain
18 herself independently until she arrived here. When
19 she arrived she had very little left in savings.

20 While in Ontario Carol didn't join the
21 Ontario Health Insurance Plan and as she would be in
22 Montreal only two months prior to the arrival of her
23 baby she wouldn't become eligible under the hospitalization
24 plan.

25 Carol was certainly not in any financial
26 position to involve herself in a large hospital debt
27 which might vary from \$135 to \$198 to cover confinement
28 and hospital costs for herself and her baby for the
29 usual seven-day period of hospitalization on a public
30 ward basis.

THIS MORNING: Carol was an 18-year-old woman from Montreal, Quebec, on the 1st, 1961, hoping to make arrangements to have her 1st child in one of the Montreal hospitals. Carol was expecting her baby on or about August 25th, 1961, and hoped, in coming to Montreal, she could keep her condition from relatives, friends, and many other unmarried mothers, Carol was unable to share her problem with anyone prior to coming here. That is with friends, with social agencies, in her own home only thought was to leave home, hide herself and she suddenly arrived in Montreal with any plans as to how she was going to manage, where she was going to stay or what she was actually going to do. While in Ottawa Carol worked as a domestic but as her condition became apparent she had to leave her job. Her savings were used to maintain herself independently until she arrived here. When she arrived she had very little left in savings. While in Ottawa Carol didn't join the Ontario Health Insurance Plan and as she would be in Montreal only two months prior to the arrival of her baby she couldn't become eligible under the hospital plan. Carol was constantly not in any financial position to involve herself in a large hospital debt which might vary from \$15 to \$100 to cover her hospital and hospital costs for herself and her baby for the usual seven-day period of hospitalization on a public ward basis.



1 Carol was encouraged to return to her
2 place of residence but she was quite determined not to
3 return to Ottawa. She did leave Montreal and we have
4 absolutely no idea of where she went or whether she was
5 able to contact proper resources for the help she required.
6 Thank you.

7 MRS. McCREA: There is one anomaly;
8 this girl could get public assistance in the City of
9 Montreal if she had been here for a 24-hour period, but
10 she couldn't get any medical care for herself prior to
11 or at the time of her confinement.

12 THE ACTING CHAIRMAN: How long must she
13 live in Quebec to be covered?

14 MRS. McCREA: Three months and a great
15 many of them do it themselves. Out of 500 girls we had
16 last year only 16 asked for any financial help from us,
17 a very small proportion. Most of them arrive in the
18 city about a month or three weeks before the baby is born
19 and it is a real medical problem..

20 COMMISSIONER BALTZAN: When you say
21 medical care, did you mean hospital care?

22 MRS. McCREA: She needed pre-natal
23 clinic services too. Not all hospitals are consistent
24 on this, but it is confused now because they don't seem
25 to know what can be collected from one province to the
26 other.

27 THE ACTING CHAIRMAN: Thank you very
28 much. Miss Forbes?

29 MISS FORBES: We have a panel of doctors
30 who are on the City of Montreal Children's Hospital and



Carol was encouraged to return to her place of residence but she was quite determined not to return to Ottawa. She did leave Montreal and we have absolutely no idea of where she went or whether she was able to contact proper resources for the help she required.

Thank you.

MRS. MCKENNA: There is one anomaly; this girl could get public assistance in the City of Montreal if she had been here for a 24-hour period, but she couldn't get any medical care for herself prior to or at the time of her confinement.

THE ACTING CHAIRMAN: How long was she alive in Quebec to be covered?

MRS. MCKENNA: Three months and a great many of them do it themselves. Out of 500 kids we had last year only 16 asked for any financial help from us, a very small proportion. Most of them arrive in the city about a month or three weeks before the baby is born and it is a real medical problem.

COMMITTEE CHAIRMAN: When you say medical care, did you mean hospital care?

MRS. MCKENNA: She needed a hospital clinic services too. Not all hospitals are consistent on this, but it is contained now because they don't seem to know what can be collected from one province to the other.

MISS MCKENNA: To have a panel of doctors who are on the City of Montreal's Hospital and



1 who make visits for us at a pre-arranged very small fee,
2 but as our foster homes are moving further and further
3 out of the city these doctors no longer have the time
4 to visit except for people that live around N.D.G. and
5 Westmount and so on.

6 More and more we are running into
7 having to call doctors who are not on our panel and who
8 charge their normal fees which are often quite high and
9 then we have to find money for this.

10 In connection with the small private
11 hospitals, the same thing applies because many of our
12 children live in the suburbs now and in the case of an
13 accident we do try to get them brought into the Montreal
14 Children's Hospital, which don't charge for out-patients.

15 Very often they do go to a small
16 hospital and we get the bill. This case, this is an
17 out-patient, where a child broke an arm on the weekend.
18 The foster parents panicked, as they often do, and took
19 the child to a small hospital and therefore she was
20 treated.

21 There was one doctor on duty and he
22 looked after her and advised the foster parents to
23 bring her to his office in the future. She went quite
24 a few times. There was quite a large bill from the
25 hospital and a very large bill from the doctor. We
26 wrote to the hospital and they were very accommodating
27 and reduced the bill, but we wrote to the doctor and he
28 said, no, he couldn't, and that was an unexpected very
29 large expense.

30 This happens quite frequently. I don't



who make visits for us at a pre-arranged time and
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and reduced the bill, but we wrote to the doctor and he
said, no, no couldn't, and that was an unexpected very
large expense.

This happens quite frequently. I don't



1 think I have any more illustrations.

2 THE ACTING CHAIRMAN: Would you
3 describe this as a common occurrence?

4 MISS FORBES: Not common, but frequent.

5 MRS. McCREA: I think we can isolate
6 it. In a group of some thousand foster children that
7 we have had in any one day there would probably be 200
8 of them that would be in really rural settings which
9 would mean rural hospitals..

10 As I say hospitals would be all right,
11 but the out-patient wouldn't. There would be charges.
12 I think in the course of a year there might be 40 or 50
13 of these bills which can run anywhere from \$37 up to
14 \$120, \$150.

15 THE ACTING CHAIRMAN: I don't know
16 where I saw this. I think I saw in the press some weeks
17 ago an announcement that the Province of Quebec was
18 going to extend the hospital diagnostic services to
19 out-patients.

20 MRS. McCREA: That is wonderful.

21 THE ACTING CHAIRMAN: Miss Girard tells
22 me there was such an announcement and it was to take
23 place the 1st of April. The 1st of April has passed
24 and it has not taken effect. That extension of the out
25 service to out-patient charges would be of great assis-
26 tance to you. It would solve this problem.

27 MRS. McCREA: If it covered the small
28 private hospitals, you see, that are in the suburban
29 areas. I don't know about the rural areas. I don't
30 know whether they would be covered or not. There would



2

1 be some discrimination - would there not; I am not a
2 medical authority - between small private hospitals
3 and the recognized government hospitals.

4 COMMISSIONER VAN WART: The small
5 hospital, does the Hospital Plan apply for in-patients?

6 MRS. McCREA: No, I wouldn't think so.

7 COMMISSIONER GIRARD: Some private
8 hospitals do come under the Hospital Insurance Plan.

9 MRS. McCREA: But not all.

10 COMMISSIONER GIRARD: Not all.

11 THE ACTING CHAIRMAN: Dr. Baltzan, have
12 you some questions?

13 COMMISSIONER BALTZAN: Just one thing;
14 if I heard you correctly, I think you made the statement
15 some hospitals are more payment-conscious. I think I
16 heard that.

17 MRS. McCREA: I would think that they
18 were.

19 COMMISSIONER BALTZAN: Would you say
20 since when?

21 MRS. McCREA: Hospitalization.

22 COMMISSIONER BALTZAN: Since hospitaliza-
23 tion. Why is this, or do you know?

24 MRS. McCREA: I wouldn't be able to say,
25 sir.

26 COMMISSIONER BALTZAN: Is it government?

27 MRS. McCREA: Whether they are having
28 much heavier demands on their services - it would seem
29 to be so to us. It is hard to get a child admitted.
30 The clinics are overloaded. There seems to be more



to some discrimination - would there not? I am not a

COMMISSIONER BATTEN: The same

hospital, does the Hospital when copy for information

MRS. McBRIDE: No, I wouldn't think so

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COMMISSIONER BATTEN: Would you say

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MRS. McBRIDE: Hospitalization

COMMISSIONER BATTEN: Does hospital

What, why is this, or do you know?

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COMMISSIONER BATTEN: Is it necessary

MRS. McBRIDE: Whether they are having

much better chance on their services - it would seem

to be so far. It is hard to get a child killed

The children are overused, there seems to be more



1 service demand.

2 THE ACTING CHAIRMAN: Miss Girard?

3 COMMISSIONER GIRARD: I think the explana-
4 tion is that hospitals are more conscious of payments
5 for out-patients because the hospital - before the
6 Hospital Insurance Plan - used to have some kind of
7 revenue, but the only revenue that the hospitals have
8 now to operate the out-patient's, where they are logically
9 losing money, is the difference between what they get
10 for the private room and the others.

11 That difference is very small since
12 the hospital doesn't even get half of it. For some
13 hospitals that don't have very many private rooms it is
14 very, very small, so the hospitals don't have the money
15 to operate their out-patient departments as easily as
16 they did before.

17 I believe, this is my opinion, that
18 this kind of attitude you are talking about, the hospital
19 must have the money to operate the out-patient's and in
20 order to get this money they must get it from some
21 source and the only source they have has been demolished
22 to a great extent so this is a problem.

23 COMMISSIONER BALTZAN: You have been
24 hiding the information. I wouldn't have had to put the
25 question if I knew you had it.

26 THE ACTING CHAIRMAN: Dr. Strachan, Dr.
27 Van Wart?

28 Thank you very much, Mrs. McCrea. I
29 am sorry we kept you so long, but we do appreciate your
30 coming and telling us something of the problems in your

collected demand.

THE CUTTING OF THE LINE: Miss G. said:

COMMISSIONER GIBSON: I think the explanation is that hospitals are more concerned of operating for out-patients because the hospital - before the Hospital Insurance Plan - used to have some kind of revenue, but the only revenue that the hospital had now no longer the out-patients, where they are losing money, is the difference between what they get for the private room and the others.

That difference is very small.

The hospital doesn't even get 10% of it. For some hospitals that don't have very many private rooms it is very, very small, so the hospitals don't have the money to operate their out-patient department as easily as they did before.

I believe, this is my opinion, that this kind of attitude you are talking about, the hospital must have the money to operate the out-patients and in order to get this money they must get it from some source and the only source they have has been demolished to a great extent so this is a problem.

COMMISSIONER GIBSON: You have been

hiding the information. I wouldn't have had to put the question if I knew you had it.

Yes, sir?

Thank you very much, Mr. G. said.

and we don't want you so long, but we do want you

and willing as something of the problem is, on



1 particular field and giving us these examples.

2 MRS. McCREA: It has been a pleasure
3 listening to the Commission.

4 THE ACTING CHAIRMAN: Thank you very
5 much. We will now rise and resume at 9.30 tomorrow
6 morning.

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8 --- Adjournment.

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1. Attached is a list of names and giving as the examples.

2. Mrs. Mabel. It has been a long time.

3. According to the Commission.

4. The Acting Director. Thank you very much.

5. Again, we will own this and receive of 100 percent.

6. Finally.

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